

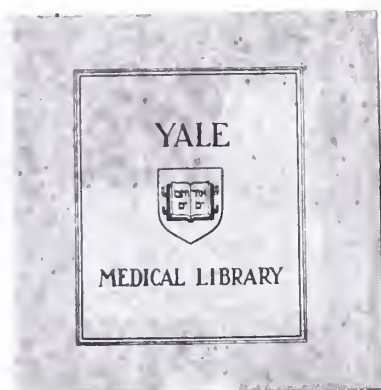


THE INTERACTION OF PATIENT AND THERAPIST
DURING REFERRAL FOR PSYCHIATRIC AFTERCARE
AT THE WEST HAVEN VETERANS ADMINISTRATION HOSPITAL



GEORGE TETER

1979





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A Thesis Submitted to the Yale University School of Medicine
in Partial Fulfillment of the Requirement
for the degree of Doctor of Medicine

1979

GEORGE TETER

NEW HAVEN

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Advisers for this work were

Richard L. Munich M.D.

and

Marc M. Rubenstein M.D. ✓

With gratitude to them

and to my wife Sonya.

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INTRODUCTION

The purpose of this research has been to look at the work done together by the hospitalized psychiatric patient and his ward therapist in planning the patient's aftercare, and to discover whether the patient's initial appearance or nonappearance at aftercare is related to this work. My hypothesis has been that nonappearance is associated with relatively low agreement between therapist and patient in their descriptions of referral issues and of referral work. Although studies have been done which describe associations between appearance at aftercare and a number of factors (demographic, diagnostic, and so on) this is to my knowledge the first look at the factor of the referral planning done by patient and therapist during the last days or weeks of hospitalization. Barton (1977) found a higher appearance rate when the patient or his MD rather than a third person made the referral; Kirk (1977) in a study in which patients were not uniformly referred at the time of discharge, found that patients referred by themselves, their families, or a CMHC were more likely to receive treatment than those referred by the courts or other social agencies. Fox and Potter (1973) and Rajotte and Denber (1963) suggest that when aftercare is made a duty of the inpatient ward, retention in treatment is improved. They do not comment on the rate of initial appearance for aftercare. Few other studies have attempted to determine whether anything about the ending of an inpatient stay affects aftercare appearance, with the exception of factors related to patient status at discharge and discharge against medical advice (Barton, 1977; Byers et al., 1978).

Thus, except for papers concerned not with research but with offering suggestions for good discharge practice (for example Gail M. Barton, 1975), certain questions concerning referral work have not been examined. Should the making of a referral be a task given the patient and his therapist? Should they spend any time attempting to discover each other's view of aftercare? Does it help if the patient knows what work his therapist may have put into a referral? If the patient is not happy with what the therapist has done (or the therapist is dissatisfied with the patient's efforts) does this matter? Can referrals be badly made? Can they be made well?

Aftercare itself has been shown to be important on a number of different levels. The lay press frequently writes about the plight of formerly hospitalized mental patients returned to "the community" without adequate places to live, protection, supervision or treatment. The fears and complaints of "the community" are of at least equal concern (see for example P. Koenig, 1978). Aftercare became a problem of acute concern for both communities and psychiatry in the 1960's with the transformations in care made possible by psychoactive drugs. Types of brief hospitalization and polymorphous experiments in community support marked the beginnings of "intermittent patienthood as a mental hospital career" (Erickson, 1975) for many patients. Individual therapy, couples, family, or group therapy, and medication appointments in mental hygiene clinics constituted only one kind of support for the formerly hospitalized. The effectiveness of this kind of support (which is what this paper means by "aftercare") has been repeatedly studied in the psychiatric literature of the 1960's and 1970's.

Substantially higher rehospitalization rates were reported without treatment after discharge. The effectiveness of these and other forms of support and treatment in getting former inpatients back to work was also assessed but with results less favorable to aftercare (Anthony, 1972; Anthony & Buell, 1973).

Against this background, factors determining appearance for after-care and persistence in aftercare became of interest. (A review of the relevant literature appears in Chapter Two of this paper.) This study attempts to add a dimension to previous investigations. Major parts of this project include a model of the work of referral based on elements of systems and group theory; sets of questions (derived from the model) asking patient and therapist to give their opinions and describe events associated with referral; a way of comparing the patient's and the therapist's answers and of obtaining a number of scores for their work together, based on the agreement of their answers; and a statistical check of the association of the scores obtained from nineteen patient-therapist pairs with the patient's appearance or nonappearance for outpatient treatment. Since research has not been done in this area before, there has been little to build on. Model, tool, and method have been devised nearly from scratch and tested by being put to use. Separate chapters will discuss problems with this research and proposals for revising the project for a more controlled and extended run. It was quite clear even well before the first patient and therapist answered their questionnaires that this would be pilot work, that it would not be possible to dip into the established relationship of patient and therapist, and obtain at the first attempt clearly reliable and valid measures of a single aspect of their work together. Nevertheless it seemed worthwhile

to try to describe how referral is approached and to see whether these preparations for the patient's migration from his ward to a clinic and from familiar therapist and treatment to the unfamiliar, have any relation to his attempting the trip.

At the West Haven Veterans Administration Hospital transfer is enough of a challenge to suggest that preparation might be important. Aftercare referrals from the two intermediate-stay wards and the diagnostic and brief treatment ward go to the Mental Hygiene Clinic officially in the form of a single sheet of paper filled in by the referring ward clinician. Inpatient and outpatient services are clearly separated. In rare cases a ward clinician may keep one of his patients in therapy after discharge. This is more common if it is December or June and the clinician (all of whom are first year residents in psychiatry, or graduate student trainees in clinical psychology) is about to rotate into the Mental Hygiene Clinic for six months of outpatient work. In the great majority of cases, however, the patient's access to outpatient individual, couples, family, group, or medication therapy depends on his crossing a distinct organizational boundary, involving a change of treatment personnel. Preparing and orienting the patient for this transition, as well as notifying the MHC are responsibilities of the ward therapists -- there is no other regularly involved person or office either within the ward, within the MHC, or between ward and Clinic. There is no official role for the patient in contacting the Clinic. Discharge, however, generally ends the role of the inpatient therapist, who is no longer responsible for the referral or for further services to the patient.

The separation of wards and Clinic (perhaps partly a survival of the Clinic's having been located in Bridgeport for many years) is served

also by the handling of referrals once they reach the Clinic. Until the summer of 1978 the MHC accepted a referral only after a patient had been discharged. Since the summer a standing transfer liaison committee in the MHC has been active to ease the passing of referrals from ward to outpatient clinician. One benefit of this committee's work is that pre-referrals may be received before discharge, and in special cases, the Clinic is able to move more quickly to get a discharged patient into aftercare. The timetable had not changed for most patients, however, at the time this work was done. Usually about two weeks after discharge, the patient received notification of his first Clinic appointment; this would be for an evaluation session with one of the MHC clinicians. The patient would then attend from one to three evaluation sessions and be judged suitable or unsuitable for treatment by the resources of the MHC. If suitable, he would be assigned a mode of therapy and a therapist. Commonly four to six weeks elapsed between discharge and the completion of the evaluation.

A complete reevaluation of each patient is considered necessary by the Clinic partly for training reasons. Part of the assignment for first-year psychiatric residents on the MHC (and to a lesser extent for psychology trainees who have had somewhat more of this experience prior to their Clinic rotation) is to learn to perform outpatient evaluations, and the model for evaluation is one that does not accept predetermination by previous work-ups.

Whether intended or not it would seem possible that the waiting period and reevaluation serve also to control the boundary (in A.K. Rice's sense; Rice, 1969) between the Clinic and the wards. An organizational analysis of the ward-Clinic relationship might point out the likelihood

of the Clinic's being or feeling imposed upon by the inpatient units. These units do not generally plan their discharge schedules or their recommendations about the urgency of follow-up with the capacities of the Clinic in mind. Their extensive knowledge of the patients, and feelings about appropriate therapy, might also put the Clinic at an initial disadvantage. In this context, an organizational analysis might also suggest that the tendency of inpatient residents and psychology trainees to arrange patient transfers informally with their counterparts in the Clinic would be far more of a problem for the administrative and teaching structure of the Clinic than for the structure of the inpatient wards. The Clinic might not want its "input" (Rice, 1969), which is an input of patients, to be predetermined by the "output" of the wards, especially along irregular lines of contact.

Still a third factor has long operated to compromise the Clinic's autonomy, namely a Veterans Administration rule concerning eligibility for outpatient treatment. The rule makes veterans who are non-service-connected for mental illness eligible for six months of outpatient treatment providing they are referred for it upon discharge, for continuing treatment of the illness for which they were hospitalized. Because of this rule, ward secretaries for a long time advised all patients to "register" with the MHC on discharge, quite independently of the clinical referral structure. Lacking clear channels of intelligence to the wards, the MHC had then to process patients who obeyed this instruction. All of these factors compromised the ability of the MHC to function independently and efficiently, and one of the tasks of the transfer liaison committee has been to gain more control over intake.

These remarks are by no means meant to be a complete statement about ward and Clinic relations. Rather than attempting to do more in this direction, the rest of this introduction will describe the researcher's view of his own experiences in the early phases of this project as an example of the problematic relationship of the MHC to the wards at that time (Fall, 1978). In seeking to formulate a research hypothesis, he had spoken to some but not all of the permanent medical staff of the inpatient wards and the MHC. The picture formed of the referral procedure from these conversations was rather different from that described above, in that patients were believed rather frequently to meet with a Clinic evaluator, and sometimes with their assigned outpatient therapist, prior to discharge. With the help of a group-theoretical approach similar to what is described in Chapter Two of this paper, sets of questions were written for patient, ward therapist, Clinic evaluator and Clinic therapist, asking how far the four of them had come and how much they had cooperated prior to discharge in accomplishing a good transfer of therapy to the outpatient side. These questionnaires were distributed fairly widely among staff on all units. After about ten days, the researcher met with staff and clinicians of each unit in turn to explain the project further and to launch it. The last presentation was to the MHC and in the middle of it several staff members commented that the questions for Clinic evaluator and therapist were superfluous, since ninety-nine of a hundred patients were never seen by anyone in the Clinic until their first evaluation appointment, four weeks or thereabouts after discharge. There was no period in which patient, therapist, and MHC clinicians all studied the same referral, and no plans to move towards instituting such a practice. In this way the first phase of this project

came to an end, having inadvertently been what lawyers might call a discovery procedure, whereby the researcher and the inpatient staff members who had given advice learned how the Clinic managed intake. The fact that it was a discovery for others besides the researcher raised the question again of what an effective referral might be. The question has at least two sides: what kind of referral is handled best by the system; and what kind of referral is the patient more likely to make good by appearing for his Clinic evaluation. I chose to continue looking at the second aspect.

In Chapter One, literature relating to appearance for aftercare, and the efficacy of aftercare is surveyed in a logical fashion in order to note the factors which have been reported to discriminate appearers from nonappearers, and to examine whether improving appearance rates might improve care. Chapter Two discusses the referral process in some detail from several perspectives in order to develop a sense of what some of the important elements in it are and how they might be asked about. Chapter Three presents the research design of this project. Chapter Four, a chapter on results, includes a discussion of certain technical aspects of the data collected and of the patient sample. Introductory to the main section on results, some difficulties encountered in the research are described. The main results section describes what was learned about the referral process in general, and what correlations were obtained with appearance or nonappearance for aftercare. Chapter Four ^{also} discusses some of the general problems of interpreting the outcome correlations. Chapter Five gives some guidelines for how this project might be developed for more controlled investigations.

CHAPTER I: REVIEW OF THE LITERATURE

In this chapter I would like to comment on the pragmatic reasons for undertaking a study of factors affecting appearance at aftercare, and to review several elements of the research literature which support this reasoning or call it in question. This will not be a complete review of every research area that bears on this matter, but will attempt to be complete in reviewing studies of factors associated with appearance or nonappearance for aftercare. The other principal areas to be reviewed in part is factors associated with rehospitalization of psychiatric patients.

The underlying pragmatic rationale for this study consists of two hypotheses:

- H.1: Better referrals will increase appearance for aftercare;
- H.2: Appearing for aftercare would benefit patients who are not coming at present.

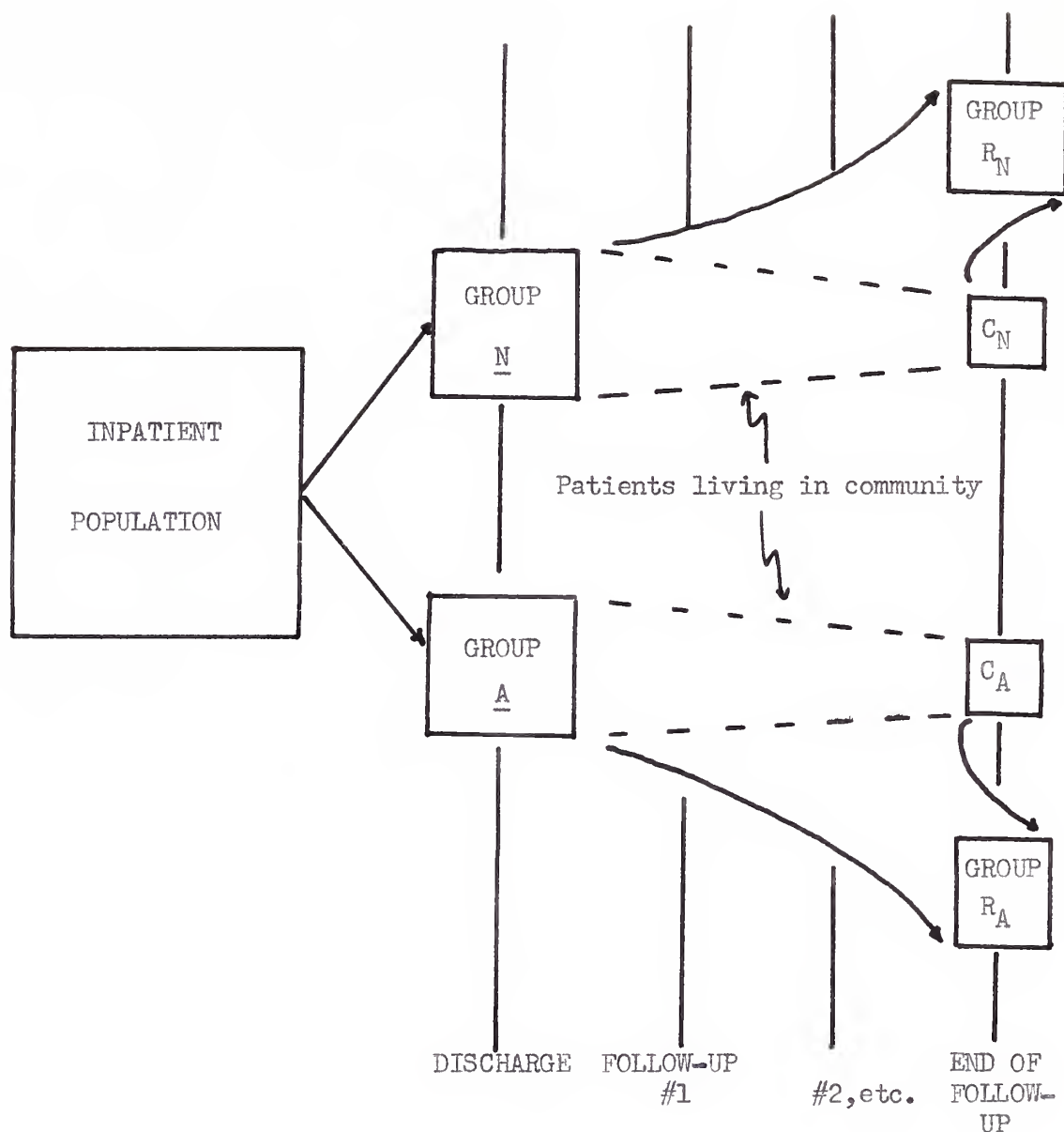
A number of parallel or supporting assumptions are also of interest.

Related to the first hypothesis above are:

- A.1: Potential nonappearers can be identified. (This has been thought important if efforts to increase aftercare appearance are to be effective and efficient.)
- A.2: Efforts of some kind can make appearers of nonappearers. For example:
- A.3: Intensified effort on the part of outpatient services can bring potential nonappearers into treatment.

Before discussing assumptions related to the second hypothesis above, several groups of patients will be named so that talking about them will be easier. The diagram on the next page shows several patient groups relevant to studies of these problems. The diagram follows patients who have been discharged and who are initially seen as divided into two

FIGURE 1



groups: N, the group who do not appear for aftercare, and A, the group who appear. As time passes these two groups each experience division into two subgroups: that of the rehospitalized (R) and that of those patients who remain in the community (C). The diagram envisions this division into R and C groups as happening in stages corresponding to times of ascertainment in a hypothetical follow-up study of the entire group of discharged patients. Let us call the group of all patients from N who have been rehospitalized by the time of the final follow-up, R_N , and the group of all patients from A who have been rehospitalized by the time of the final follow-up, R_A . Other groups could be identified. Patients lost to follow-up, for example, is a group parallel to A and N. Patients who begin treatment but drop out, patients in treatment at any given follow-up, and their respective contributions to R_A could be discussed, but will not be as important in this review as the first-named groups.

Going back to the two principal hypotheses, assumptions related to the second (appearing for aftercare would benefit patients who are not coming at present) can now be stated. They include:

- A.4: Group A has lower measures of rehospitalization than group N.
- A.5: Group R_A are discriminable from the whole of group A by certain factors.
- A.6: Members of R are discriminable from the whole discharge group by certain factors.
- A.7: Potential members of N who are made into actual members of A by some special effort will not elevate the rehospitalization rate of group A.

The last assumption above is a specific statement of one interpretation of H.2, which says more broadly that potential members of N would benefit by being brought into A. Actually it is important to be more specific than A.7, since if the benefit under discussion is decreased hospitalization,

our wishes for the members of N apply especially to R_N , those members of N who are rehospitalized. Assuming that entry into treatment would not cause members of N to be rehospitalized who would not otherwise be rehospitalized (not an altogether safe assumption), A.7 can be made more specific as:

A.8: Potential R_N 's made into members of A will share the rehospitalization rate of A.

A contrary assumption, and a plausible one, is:

A.9: Potential members of R_N who are brought into A will simply become members of R_A .

That is, since R_N consists of rehospitalized patients who for one or another reason (motivation, for example, or pathology or poor community support) did not even attempt outpatient treatment, they will do poorly even if they could be got to attend. If A.9 were true it would to some extent argue against efforts to bring members of N into treatment. Considering, however, that there may be benefits from being in treatment not measurable simply by rehospitalization or not, a reply to A.9 can be stated. In order to stay within the framework both of the current discussion and of most of the literature in the area, it should say:

Potential members of R_N who are brought into A will share the rate of rehospitalization of R_A .

As a testable hypothesis this would be:

A.10: Potential R_N 's brought into A will not elevate the rehospitalization rate of R_A .

This assumption still gives the R_N 's the benefit of the doubt -- since they may well be poorer risks than the R_A 's -- but it provides a fairly specific and stringent criterion for the worthwhileness of efforts to encourage aftercare attendance. Or rather it does, assuming that the rehospitalization rate for the R_A 's is lower than that for the R_N 's:

A.11: The rehospitalization rate for R_A is lower than that for R_N .

This discussion of the literature will try to identify what work has been done in the areas of these assumptions. As it happens, some have been heavily worked over and others not at all. For brevity and convenience, the papers under review have been listed in one or both of two tables, giving some of the more relevant characteristics of each study.

Articles relevant to A.1 are reviewed in the table Receipt of After-care. As can be seen, studies differed not only in numbers, referring and treating institutions, and type of treatment, but also in diagnostic categories allowed in the sample (Orlinsky & D'Elia, Raskin & Dyson restricted to schizophrenics; Pratt an example from the alcoholism literature; Anthony & Buell, Barton, Kirk & Byers all excluding patients with primary alcoholism and some of them also excluding patients with drug dependence, mental retardation, and organic brain syndromes). Another important difference is whether the sample selection includes a referral criterion; Kirk, Pratt, and Byers do not state that their patients were referred for aftercare. No study compares appearance rates for referred and unreferred patients. There is some uniformity in the meaning of "receipt of care," which for most studies means one or more appearances; this is not the case however for Kirk, and the definitions in Raskin, Dyson and Winston are vague. (Note specifically however that none of the studies in this table, except Raskin & Dyson, are concerned with describing patients who leave treatment against advice. The literature on patient drop-outs is different and more extensive.)

The second-last column lists factors found to correlate with receipt or nonreceipt of care. Only Anthony and Buell is unrepresented here.

TABLE 1a

RECEIPT OF AFTERCARE (1)

STUDY	REFERRED?	PATIENT POPULATION	FURTHER SAMPLE CRITERIA
Orlinsky & D'Elia 1964	Yes	All Chicago residents given "conditional" discharges between 7/57- 7/60, except: 9-died 10-discrepant records 180-hospitalized before 7/49	schizophrenics
Raskin & Dyson 1968	Yes	45 consecutively admitted patients with at least 1 prior admission to the same service.	schizophrenics
Anthony & Buell 1973	Yes	"Nearly all" patients discharged in 1970 from 1 hospital, except: 12-records lost.	None with primary diagnosis of mental retardation, alcoholism, or organic brain syndrome.
Barton 1977	Yes	Patients discharged from 1 hospital between 5/1/75-6/17/75	None with alcoholism, drug dependency, or mental retardation.

See Table 1b for further articles.

TABLE 1a

RECEIPT OF AFTERCARE (2)

REFERRING INSTITUTIONS	AFTERCARE FACILITY/ MODE OF AFTERCARE	DEFINITION OF GROUPS N AND A	SIZE OF GROUPS N AND A
All Illinois state hospitals	Chicago CMHC/ mostly monthly interviews and "tranquilizing drugs"	N: no visits despite 2 letters of appointment. A: one or more visits.	796 (37%) 1336 (63%)
Community Psychiatry Service of the University of Pennsylvania	Same	N: no visits within 1 year. A: ?	15 (33%) 30 (67%)
State hospital	"Aftercare clinics in the community."	N: no visits (period not specified). A: one or more visits.	40 (51%) 39 (49%)
Dorothea Dix State Hospital, Raleigh, N.C.	"Nearby CMHC"	N: did not appear for 1st appt. A: kept 1st appt.	22 (37%) 38 (63%)

TABLE 1a

RECEIPT OF AFTERCARE (3)

FACTORS FOUND TO CORRELATE WITH N AND A	FACTORS FOUND NOT TO CORRELATE WITH N AND A
<p>A: more likely to be nonwhite; 8th grade ed. or higher.</p> <p>Also hospital of origin differences in proportion of patients in A or N.</p>	<p>Sex, economic status, marital status, length of hospitalisation, legal status on admission, subclass of schizophrenia</p>
<p>12 members of N were stormy, impulsive, disruptive in community.</p>	<p>None stated.</p>
<p>Multiple linear regression analysis of variables on right accounts for 13.9% of variance in N vs. A membership.</p>	<p>Marital status, employment history, age, race, sex, diagnosis (schiz- ophrenia vs. other), number of hospitalisations, length of last hospitalisation, educational level, occupational level.</p> <p>all p's were $> .08$.</p>
<p>A: "more likely" to be <u>white female</u>; <u>married</u>; <u>45-64 y/o</u>; high school graduate; on Disability Income; involuntarily committed; <u>schiz-</u> <u>ophrenic</u>; <u>twice or more hos-</u> <u>pitalised at Dix</u>; given discharge plans by Dix. However, only underlined factors statistically significant at $p < .05$.</p>	<p>Factors at left that are not underlined are not significantly correlated with membership in N vs. A.</p>

TABLE 1b

RECEIPT OF AFTERCARE (1)

STUDY	REFERRED?	PATIENT POPULATION	FURTHER SAMPLE CRITERIA
Kirk 1977	Not stated	All region residents discharged from a Kentucky state hospital from 7/1/71-6/30/72	No patients with alcoholism, drug dependence, or mental retardation.
Pratt, Linn, Carmichael, & Webb 1977	Not stated	Patients receiving a "regular" discharge and living within 40 miles of hospital. 11 month intake period.	Alcoholic patients completing an 8-week inpatient substance abuse program.
Winston, Pardes, Papernik, Breslin 1977	Yes	All patients admitted to unit during 2 1/2 years except 98 (46.2%) who could not be contacted for follow-up.	
Byers, Cohen, & Harshbarger 1978	Not stated	All patients discharged or released on "trial visit" to a 3-county area from 7/1/71 - 6/30/73.	None with primary problem of alcoholism.



TABLE 1b

RECEIPT OF AFTERCARE (2)

REFERRING INSTITUTIONS	AFTERCARE FACILITY/ MODE OF AFTERCARE	DEFINITION OF GROUPS N AND A	SIZE OF GROUPS N AND A
All Kentucky state hospitals	3 regional CMHC's	N: no visits or intake interview only A: came at least once after intake	260 (45%) 319 (55%)
Veterans Administration Hospital, Miami, Fla.	Same	N: no sessions attended within 3 mo. of discharge. A: at least 1 session att. in 3 mo.	22 (65%) 13 (37%)
Municipal hospital, therapeutic community unit	Facility not stated/ Individual psycho- therapy, group psycho- therapy with or with- out medication	N: "no treat- ment" A: "treatment"	25 (22%) 89 (78%)
State hospital, W. Virginia	CMHC / "mainly monthly home visits with occasional medication checks"	N: received no services prior to readmission or within 1 year. A: received services	50 (39%) 79 (61%)



TABLE 1b

RECEIPT OF AFTERCARE (3)

FACTORS FOUND TO CORRELATE WITH N AND A	FACTORS FOUND NOT TO CORRELATE WITH N AND A
<p>"More likely to receive care" if: female; schizophrenic or neurotic vs. other diagnoses; referred by self, family, or CMHC than if referred by courts or other agencies.</p> <p>No significance measures.</p>	
<p>A: fewer people in household ($p < .05$); more likely to perceive ward as: encouraging autonomy ($p < .05$); accepting expressions of aggression ($p < .10$); encouraging insight ($p < .10$).</p>	<p>Age, race, marital status, income, education, work history, number of hospitalisations, number of convictions, motivation, nine other "ward atmosphere factors" had "no statistical significance"</p>
<p>Males less likely to attend than females;</p> <p>"trend" for single patients to enter treatment less often than marrieds.</p>	<p>Age, race, marital status, diagnosis.</p>
<p>A: female ($p < .01$); nonalcoholic ($p < .01$); discharged from experimental unit ($p < .05$); psychotic as opposed to mentally retarded or having organic brain syndrome ($p < .10$)</p>	<p>Religion, county of residence, marital status, years of ed. completed, occupational class, age at 1st or key adm., status at key adm., suicidal tendency; no. of adm., age or status at discharge, type of separation, with or against med. advice, length of hosp., total time of all hosp., chronicity, source of funds, relation to person de'd to</p>



There is very little overall agreement, however, except that attenders are more likely to be female (not found by Orlinsky, the largest study), and in most studies with diagnostically heterogeneous groups, schizophrenic or psychotic patients were more likely to attend than certain other categories. Otherwise one sees great variety in the findings. Note findings in Orlinsky that hospital of origin affected attendance, and in Byers, that unit of origin affected attendance. Whether these are related to referral practices (and hence evidence for H.1) is indeterminate. The type of analysis used to identify correlations in most of these studies seems to be chi-square testing (although this is frequently not stated). Anthony and Buell are the only researchers to see how much of the variance in receipt or nonreceipt of care can be accounted for by their factors. Their list of ten demographic and hospitalization factors (none of them singly correlated at $p < .05$ with receipt of care) account for only 13.9% of the variance.

The last column lists factors found not to correlate with receipt of aftercare. The great majority of factors tested appear here, drawn mainly from demographic and hospitalization measures. Some of these will be discussed with A.9.

In all of the studies that use statistical tests for correlating patient characteristics with attendance, a great many characteristics are separately examined. Anthony and Buell again, with an analysis of variance design, are the only investigators to control for the fact that when examining such large numbers of correlations, several significant results are apt to be expected by chance alone.

In summary it would seem that differences between study findings are far more marked than differences between nonattenders and attenders. At

present, if one were to try to design a more carefully controlled study of the effects of certain factors on receipt of aftercare, the general literature gives little guidance over what to control for, except sex and diagnosis. Beyond that a choice of controls would have to consider factors which are possibly specific to the population and sample, or to the types of institutions and care involved. In commenting on the literature on patient dropouts, Fiester and Rudestam (1975) wrote: "The proclivity of earlier investigators to conceptualize dropouts as being characteristic of a single type of patient seems to be another unfounded homogeneity myth." Although there has been less mythmaking in the receipt of aftercare literature, the same general evaluation might be repeated here.

Assumption A.3, that intensified effort by outpatient services can bring potential nonappearers into treatment, is tested by only one research design (a design using each patient as his own control) that of Raskin and Dyson, whose sample of schizophrenics is a target group of recidivists identified for intensified efforts at getting them into and retaining them in aftercare. The attempt to get former members of N into A (presumably mainly done by the outpatient service, although it is not clear that the inpatient side did not also participate) involved 16 patients who had failed to appear for aftercare following the previous hospitalization. It netted only 2 into aftercare. Among the other subgroups, one patient who had previously attended could not be brought back. Thus the only evidence available is unfavorable to A.3.

The hypothesis that better referrals will increase aftercare appearance (H.1) is not directly approached by any study. The possible relevance of hospital of origin differences in appearance for care has been mentioned.

TABLE 2 a: RELATIONSHIP OF AFTERCARE AND REHOSPITALISATION (1)

STUDY	POPULATION & SAMPLE(S)	TYPES OF TREATMENT	MEASURES OF REHOSPITALISATION	REHOSP. RATE
Rajotte & Denber 1963		Group I: follow-up by inpatient treatment staff. Group II: referred to clinic.	Rehosp. within 2 years of discharge.	32% 52%
Orlinsky & D'Elia 1964	See Table 1a	Monthly "psychiatric and social interviews; low to moderate dosages of tranquilizing drugs. Also, activities groups and relatives' groups & counseling.	% in community at follow-up: 30 days, A/N = 60 days, A/N = 90 days, A/N = 182 days, A/N = 365 days, A/N = 730 days, A/N =	99.7/95.5 97.9/90.9 95.0/85.0 87.9/69.7 74.3/54.5 59.4/46.6
Sheldon 1964 (English)	Women ages 20-59. Dx: depression or schizophrenia. Discharged to community betw. 10/61-3/62.	I. Referred to G.P. II. Referred to Day Centre. III. Referred to Outpatient Treatment.	Rehosp. within 6 months of discharge.	47% 19% 17%
Raskin & Dyson 1968	See Table 1a	OPT by 1st yr. residents at Comm. Psychiatry Service, U. Penn. Extra care taken to retain pts. in treatment. Family treatment & vocational rehab. prn.	Rehosp. within year of discharge. I. No aftercare. N=15 II. In aftercare. N=29 III. Dropouts. N=1	53% 38% 100%
Zolik, Lantz, Sommers 1968		Outpatient mental health services or other community support agencies.		

See Table 2b for further articles.

TABLE 2a: RELATIONSHIP OF AFTERCARE AND REHOSPITALISATION (2)

TYPE OF STUDY	FACTORS RELATED TO REHOSPITALISATION	FACTORS UNRELATED TO REHOSPITALISATION
Survey. Significance level p .01.	Membership in N vs. A at all periods of follow-up. Fewer than 5 interviews at 1 yr. follow-up.	Early vs. late attendance at aftercare. Fewer than 5 interviews at 2 yr. follow-up.
Experimental. "Random" referral to one of three aftercare modes.	Referral to G.P. vs. to psychiatric aftercare p .01. Schizophrenics referred to G.P. vs. to psychiatric aftercare p .02 "Trends" in favor of "good" psychiatric attendance and "frequent" G.P. attendance.	Day Centre vs. Clinic care "Intensity" of psychiatric aftercare.
Experimental. Intensified efforts to begin and con- tinue aftercare for recidivist pts. Pts. their own controls.	"For some patients": change of therapist at discharge, and loneliness in community lead to re- hosp. Intensified program has 44% rehosp. rate in 1 yr. for pts. who before had relapsed after mean 7 mo. in community.	None identified.
Experimental. Group I released with aftercare referral. Group II released without aftercare referral.	Group II returns at higher rate; and higher relative frequency of Group II returns during follow-up period.	

TABLE 2 b: RELATIONSHIP OF AFTERCARE AND REHOSPITALISATION (1)

STUDY	POPULATION & SAMPLE	TYPES OF TREATMENT	MEASURES OF REHOSPITALISATION	REHOSP. RATE
Claghorn & Kinross-Wright 1971	Pts. arriving at clinic with referral after discharge from Austin State Hospital.	I. No treatment after study intake interview. (Control) N=155 II. Mainly monthly visit with phenothiozines. (Exp.) N = 626	% re hosp. at each follow-up 6 mo. I/II = 12 mo. I/II = 18 mo. I/II = 24 mo. I/II =	%/% 23/12 39/17 51/22 58/24
Franklin, Kittredge, Thrasher 1975	107 pts. selected "at random" from state hospital discharges over 1 yr. Alcoholic & nonalcoholic subsamples. Not stated if referred.	Not stated.	Re hosp. betw. 6-13 mo. after discharge. Overall re hosp. rate (alcoholic & nonalcoholic pts.)	 34%
Winston, Pardes, Papernik, Breslin 1977	See Table 1b	Individual or group psychotherapy with or without meds.	% re hosp. within year of discharge Group N (nonattenders, 25 pts.) Group A (attenders, 89 pts.)	 52% 20%
Byers, Cohen, Harshbarger 1978	See Table 1b	Mainly monthly home visits with occasional med. checks.	I. Readm. within 1 year N/A = II. No. of days in comm. with in 1 yr. N/A = III. No. of days to 1st readm. N/A =	%/% 44/32 ns. days/days 323/329 ns. days/days 250/285 s.
Anthony & Buell 1973	See Table 1a	"Aftercare clinics in the community."	% re hosp. within 6 mo. of discharge Group N (40 nonattenders) Group A (39 attenders)	 32% 15%

ns.= nonsignificant; s.= significant

TABLE 2b:RELATIONSHIP OF AFTERCARE AND REHOSPITALISATION (2)

TYPE OF STUDY	FACTORS RELATED TO REHOSPITALISATION	FACTORS UNRELATED TO REHOSPITALISATION
Experimental/Survey Control (no treatment) and experimental (treatment) groups. Factor analysis to separate re hosp. group from non-re hosp. group	Membership in Control vs. Experimental Group. "Differences" (no sign. criteria or direction given) betw. re hosp. and non-re hosp. groups on five factors:family relations; drug compliance;agitation; attitude to clinic;manifest psychosis.	Eight other factors not described in paper on which no "differences" distinguish re hosp. and nonre hosp. groups.
Survey comparison of re hosp. and nonre hosp. pts. on 52 factors with sign. criteria of $p < .05$.	For nonalcoholic subsample, re hosp. pts. more likely to:have income from source other than self or family; have more CMHC contacts; use services of other agencies; fewer visits from friends/relatives; more alcohol-related probs.	Numerous factors related to medication use and social existence.
Survey.	Schizophrenics more likely to be re hosp. than other dx. groups. Schizophrenics in N sign. more likely to be re hosp. than schizophrenics in A. "Trend" for paranoid schizophrenics to be re hosp. at higher rate if change therapist at disch.	Last two findings at left do not hold for dx. groups other than those stated.
Survey. Test of multiple variables for correlation with outcome measures. Multiple regression analysis for factors accounting for variance in outcome measures.	I. 7-variable factor with $R^2 = .326$. II. 5-variable factor with $R^2 = .276$. III. 9-variable factor with $R^2 = .386$. Several zero-order correlations cited, with ? significance.	Numerous demographic, inhospital and situational variables.
Survey.	Membership in N vs. A "significantly" related to rehospitallisation frequency over follow-up period and accounts for 4% of variance in re hosp.	None stated.

Kirk notes that self, family, or CMHC referrals are more likely to be followed up on than referrals by the courts or other community agencies.

The remaining assumptions relate to studies in the table, Relationship of Aftercare and Rehospitalization as well as to Receipt of Aftercare.

It is important again in using this table to note differences in sample populations and in the follow-up practices by which receipt of treatment and rehospitalization were ascertained. Measures of rehospitalization and measures of receipt of aftercare also vary, with several studies using more than one measure in an attempt to provide more discriminating results. This means that groups A and N as defined above are not relevant to some of the results of these studies. Type of aftercare varies from paper to paper. Major differences appear also in the type of study. Some have experimental designs (none of these define groups compatibly with the definitions of A and N given here.) Rajotte and Denber vary the source of aftercare (or the source to which the patient is referred). Raskin and Dyson, in a study in which each patient is his own control, vary the intensity and quality of aftercare. Zolik compares groups released with and without aftercare referrals. Claghorn and Kinross-Wright compare two randomly selected groups of patients seeking aftercare, one of which is accepted for treatment and the other turned away.

The remainder are descriptive studies with varying methodology, concerned with the relation of different factors to rehospitalization. They share an interest in aftercare as one factor (less clearly defined in Franklin than in the others), and follow groups of patients whose participation in aftercare is determined by variables outside the control of the investigators. Although all these papers, except Franklin, consider A and N groups, some also consider aftercare measures that would define

additional groups. Orlinsky and D'Elia's large study of schizophrenics reports highly significant differences in rehospitalization rates at each of six follow-up periods between A and N. Winston reports significant results in the same direction both for his overall N and A groups, and for the schizophrenic subgroups of A and N, but not for diagnostic subgroups other than schizophrenia.

The two descriptive papers offering the most sophisticated analysis of A.4 (group A has lower measures of rehospitalization than group N) are able to support it, but assign it only limited importance. Anthony and Buell find that membership in A or N, while significantly related to rehospitalization, accounts for only 4% of the variance in rehospitalization. Byers, Cohen, and Harshbarger report a significant ($p < .10$) advantage for group A vs. N in only one of three measures of rehospitalization: number of days to first readmission. Furthermore, in a stepwise multiple regression analysis of fifty-two factors including receipt of aftercare, the multifactoral models which emerged to account for variance in the three measures of rehospitalization either did not contain measures of aftercare or contained them in relatively minor roles. The most important measure of aftercare was not receipt of care (the definition of group A) but frequency of aftercare. Winston's finding that A.4 is supported by considering the subgroup of schizophrenics was not tested in these papers. Byers et al. and Anthony and Buell do not give the proportion of schizophrenics in their samples and do not calculate results separately for different diagnostic groups. In summary, evidence for A.4 is strong but the importance of A.4 is undecided. This is not surprising, since beside the fact that samples are differently drawn and the offerings

(and hence perhaps the availability and attractiveness) of aftercare facilities are markedly different, A.4 rests on a very weak conception of treatment, that is, appearance for one or more aftercare sessions of whatever kind. (Nevertheless, two experimental studies with a still weaker distinction between groups, namely Zolik et al. and one part of Sheldon's study, confirm the advantage of the treatment group.)

The next assumption, that group R_A are discriminable from the whole of group A by certain factors (A.5), permits stronger definitions of treatment to emerge in the form of discriminators between R_A and the balance of A. Here, the three studies by Orlinsky and D'Elia, Byers et al., and Sheldon find frequency of treatment measures to discriminate significantly within A. (Rajotte and Denber report lower rehospitalization rates for patients referred for aftercare to their former inpatient wards, than for patients referred to an outpatient clinic. However since referral rather than treatment forms their criterion, it is unclear whether their comparison is truly between two subgroups of a treated group.) Raskin and Dyson demonstrate that retaining in aftercare patients who had formerly dropped out or been prematurely terminated and who had then relapsed, may prevent or delay (during a one-year follow-up) further rehospitalization. Incompleteness in the data given about the time to prior relapse of these patients makes it difficult to assess exactly the amount of delay achieved. Again, however, the only study which analyses variance in rehospitalization (Byers et al.) reports only a small share for the frequency of treatment factor, with items unrelated to aftercare emerging in more powerful roles. These authors conclude: "The ambiguity of these results resembles inconsistencies seen in findings from prior studies, and suggests that recidivism is a complex phenomenon which can

neither be predicted nor explained through any single factor but only by examining the interaction of a variety of factors." (Byers, Cohen, & Harshbarger, p. 32).

It is beyond the scope of this review to describe the whole "variety of factors" that have been elicited by different studies to predict or explain membership in the rehospitalization group (R). Instead the next assumption (A.6: members of R are discriminable from the whole discharge group by certain factors) will be considered only in relation to the assumptions that follow it, which define its pragmatic significance with increasing exactness. Anthony and Buell are aware of this use of data for A.6, for in explaining the dual task of their study they say: "if the results [of the demographic comparison of A and N groups] indicated that clinic attenders differed from nonattenders on the same demographic variables that have been positively correlated with recidivism in previous studies, it may be that the positive effect of aftercare clinics reported in past research is due to the fact that they provide services to the better risk patients" (Anthony & Buell, p. 116). Clearly then what has to be considered is the group of assumptions about the benefit or lack of it to be had by making potential members of N into members of A. For this literature, the index benefit is reduced rehospitalization. First though it should be noted that of the studies under review only Orlinsky and D'Elia offer a comparison of R_A and R_N , or of R_A and N. It is not apparent why this has not been offered in other studies, since data are available for the whole of each group and the subgroups are always identified in the course of the study. Perhaps uncertainty about the accuracy of follow-up is to blame. In any case, most of these studies offer comparisons of broad heterogeneous groups rather than more powerful

comparisons of smaller groups that are alike in having been rehospitalized if in nothing else. In these papers neither the groups nor the individuals within them have been matched. Another way of putting this is to point out the logical weakness in Anthony and Buell's formulation. Suppose "poorer than" were a demographic variable found to differentiate both attenders and nonattenders, and recidivists and nonrecidivists. Does this imply that nonattenders as a group are so poor as to be recidivists even if they were to receive treatment? Logically it does not. Validation of the argument would require at least separate descriptions of the poverty level of recidivist attenders and recidivist nonattenders, since treatment might be hoped to enable poorer people to stay out of the hospital. Without data about R_A and R_N we cannot decide this.

Four studies lend themselves to discussion of these issues. Anthony and Buell found no significant differences between A and N and in particular none on two factors (length of previous hospitalization and number of previous hospitalizations) they consider to offer the best record for separating rehospitalized and not rehospitalized groups. Thus their data supports A.7 (potential members of N made into actual members of A by some special effort will not elevate the rehospitalization rate of group A). Byers et al. contrast their findings with Anthony and Buell, and in examining their results one finds that sex, diagnosis, and unit of origin are correlated with both membership in A vs. N, and with rehospitalization vs. no rehospitalization. However a glance at the second-last column on table 2 shows that none of these factors were among the major discriminators for any of their measures of rehospitalization. Orlinsky and D'Elia, who offer R_A and R_N data for a large number of factors, do not discuss this matter and do not report factors that discriminate R_A from R_N .

Calculations based on their data show that at least one factor, nonwhite male vs. all other race/sex categories, does yield a slight but significant differential between the two groups. Members of R_A are slightly more likely than members of R_N to be nonwhite males and nonwhite males, by the authors' analysis, are a more frequently hospitalized group. This is a taste of the kind of evidence that might support a specific assumption like A.10 (potential R_N 's brought into A will not elevate the rehospitalization rate of R_A). Winston et al. in their study report no factors that mutually discriminate between N and A, and between rehospitalization and remaining in the community. Thus overall there is a lack of data that would seriously question assumptions like A.7 and A.10. The most serious question to it, as several authors realize, arises from the untested factor, motivation for treatment.

A final and important assumption remains to be tested, A.11, which allows us to argue that even if groups R_N and R_A turn out to be very similar, the experience of treatment would benefit members of R_N . Again, no study addressed this question. However, data of Claghorn and Kinross-Wright, and of Orlinsky and D'Elia can be used to test an hypothesis that the rate of rehospitalization for R_A is less than that for R_N . Tables 3 and 4 show this derived data, calculated from tables in the two studies which give rehospitalization rates for all of A and all of N for each follow-up period. By calling the two-year totals of rehospitalized patients R_A and R_N respectively, the speed with which these totals were reached can be calculated. Note that Orlinsky and D'Elia's data favor the R_A group fairly substantially; all of these figures are highly significant. Claghorn and Kinross-Wright's data favor R_N , but are nonsignificant ($p > .05$). Since their paper in fact compares two subgroups of what

TABLES 3 AND 4

Orlinsky and D'Elia 1964

Rehospitalisation of R_N and R_A by follow-up date.

30 days post-discharge	$R_N = 36$ $R_A = 4$	8.4% of 2-year total 0.7%
60 days	$R_N = 72$ $R_A = 28$	16.9% 5.2%
90 days	$R_N = 119$ $R_A = 67$	28.0% 12.4%
182 days	$R_N = 241$ $R_A = 162$	56.7% 29.9%
365 days	$R_N = 362$ $R_A = 343$	85.5% 63.3%
730 days	$R_N = 425$ $R_A = 542$	100 % 100 %

Claghorn and Kinross-Wright 1971

Rehospitalisation of R_N and R_A by follow-up date.

6 months post-discharge	$R_N = 36$ $R_A = 75$	40.0% of 2-year total 50.0%
12 months	$R_N = 60$ $R_A = 106$	66.7% 70.7%
18 months	$R_N = 79$ $R_A = 138$	87.8% 92.0%
24 months	$R_N = 90$ $R_A = 150$	100 % 100 %

Both tables represent derived data.

would be regarded as A in any other study (all patients received an initial interview, after which the "N" group was created by denying further treatment to every fifth patient) it is questionable whether the trend to relative equivalence in rehospitalization rates for R_A and R_N in this study constitute evidence against A.11.

Because the aftercare literature uses rehospitalization as its measure of benefit, this measure has been used here. However it is questionable how valuable a measure it is. In his review (Erickson, 1975) Richard Erickson extensively describes the weaknesses of community stay data, both in terms of problems in defining it and in terms of its basic meaning. About the data itself he notes that "what promised to be simple has become complicated; few conventions have emerged." (*ibid.* p. 520). The more serious question is what rehospitalization means in the life of a chronic mental patient. "Once the problem was chronic hospitalization. With shorter stays, the problem has become one of making an impact on the chronic patient" (*ibid.* p. 526). It is an unsettled issue whether rehospitalization does not play an important role in this process. If so, then clearly aftercare cannot be evaluated solely on the basis of the rehospitalization rates associated with it. If aftercare really "does no harm" then one might expect that the somewhat favorable review in this chapter given aftercare and the efforts to get more patients into it, might be supplemented by a consideration of benefits not yet assessed in the literature. Among these might be not only new measures of patient improvement, but also of the form of interplay achieved between inpatient stay, referral, aftercare, and rehospitalization.

CHAPTER TWO: A MODEL FOR AFTERCARE REFERRAL

The patient should be prepared for what therapy he will be having postdischarge, and arrangements should be finalized with the provider so that the patient may start attending pre-discharge. This provides better continuity of care, less panic at discharge, and greater likelihood that follow-up care will be received.

(Barton, G.M., 1975)

This prescription and similar ones in other sources (e.g., Maxmen et al., 1974) are part of a model of inpatient care which has been developed from far-reaching propositions like the following: "For most patients the major function of psychiatric hospitalization should be preparing for aftercare" (*Ibid.*, p. 209). (In this context "aftercare" implies everything included in the usual discharge planning -- a broader usage than that of this paper.) Short-term hospitalizations and numerous kinds of community support and outpatient treatments are features of the world in which this model is meant to be used. Achieving "continuity of care" in this world requires inpatient planners to have arranged, by the time of discharge, for much of the hospital program to be immediately continued outside the hospital by other means. The patient is included among these inpatient planners: "At the very least, the team should consist of the hospital therapist and the patient who should set goals for treatment in the hospital and beyond" (Barton). For psychotic patients it has been suggested that since "Relationships with hospital staff members are fragile, and...are transferrable with difficulty, if at all, to new caregivers in an outpatient setting" (May, 1975), the best continuation would be for inpatient staff to provide follow-up services for

the patients discharged from their ward (see also Fox & Potter, 1973; Rajotte & Denber, 1963; Johnson et al., 1975). In any case, allowing treatment-free periods to intervene between inpatient stay and follow-up is thought unwise and perhaps somewhat unprofessional. The appeal of this way of thinking, even in a hospital where the outpatient side has never been organized by this model, is illustrated in the story of the first version of this project.

The present chapter will consider difficulties with these prescriptions for transferring treatment to the outpatient side, and describe informally a somewhat different model of the processes that go into making aftercare referrals, which is applicable where such prescriptions do not hold.

The first difficulty lies in organizations. Most of the mental health systems in which the work reviewed in the preceding chapter was done, consisted of entirely distinct inpatient and outpatient units, mostly within different institutions. Each of these systems would encounter some of the kinds of inter-organizational difficulties active in the WHVAH system: staff training functions requiring reevaluations of new clinic patients; incoordination between inpatient discharge schedules and clinic capacity, either as a whole, or as capacity within various modes of treatment; threats to the clinic's boundary from informal referral arrangements made by therapists; external pressures from service and health coverage regulations specific to private or state or VA programs; different professional disciplines preeminent in different facilities; and in many cases, geographical separation of facilities. Not every inpatient unit is able to send out a sympathetic shout in the form of its own outpatient services. Not every referral under these

conditions will be made soon enough so that the patient for a time can be both on his ward and in the clinic.

Other difficulties may be said to reside in intellectual causes. Coordination between units may be especially difficult when therapists on both sides are first-year trainees, often lacking experience in the opposite setting. In- and outpatient units may be ideologically separated. The predominant treatment mode of an outpatient facility may not be what an inpatient therapist thinks best for his patient. There may be no generally agreed upon indications for specific outpatient treatment for specific kinds of patients. Some work has been done describing the kinds of patient-therapist match associated with the patient's dropping out of treatment (Fiester & Rudestam, 1975; Baekeland & Lundwall, 1975) but it may not be possible for a clinic to assign new patients by these findings. Finally, it is not clear that the effort required for close in- and outpatient coordination is important for all patients. "Motivation" for treatment is a factor often mentioned in the literature on appearance for aftercare, but not defined or tested in those studies. In the drop-out literature, where motivation has been tested (see review in ibid., pp. 766-767) Baekeland and Lundwall found it a term with no constant meaning; still, 34 of 41 studies reviewed by them thought it important in deciding whether a patient left treatment prematurely. In practice, inconstancy of meaning would seem especially troublesome with such a term, since "motivation" could be conceived as a cast of mind or will enabling a patient to make his own referral and follow it up, or as a power of habit that works best when others make the decisions. Baekeland and Lundwall mention such disparate interpretations, which one expects

would create conflict and uncertainty in institutional settings.

Although these difficulties are not arguments against the model presented by Barton and others, they suggest that in many settings there will be sufficient organizational and intellectual reasons for that model not to be followed. Therefore it seems reasonable to describe the way referral works in an actual system, and to see whether the extent to which referral approaches an approachable model seems related to success in transferring patients.

The model to be described presents the work of making a good referral as a task for patient and therapist, who are seen as the two particularly active members of a group of ward people involved in discharge planning. Using the notion of a group task engages certain perspectives from group theory which help to identify what therapist and patient might do and value as they plan for aftercare. The rest of this chapter will discuss these acts, plans, and values and the writings on groups which suggest them. The goal of this discussion is to present an enlarged image of referral work in general, so that actual referrals can be examined for completeness and some of their deficiencies understood. In a general way the referral work of a patient and therapist will ultimately be described by noting whether they share certain basic information; whether they agree about certain measurements of the referral situation including the roles each of them should play and the goals they want to reach; whether they are aware of one another's assessments and expectations; and whether they are aware of and approve of each other's acts and plans in referral work, especially involving relations with others outside their dyad.

On a short-stay ward where discharge is always just around the corner,

the task perspective probably underlies the clinician's relationship with most of his patients throughout the week or two of hospitalization. The inpatient stay is largely a preparation for discharge (and perhaps a preparation of the patient's outside world as well). On wards where stays are measured in months or years, however, a different relationship develops between patient and therapist, and between patient and ward, in which matters such as outside living situations, relations with parents and family, employment, and outside therapy are discussed more in the service of exploring a patient's difficulties or his pathology, than of actually arranging his leavetaking. The question of a task group orientation is then whether, as discharge approaches, the patient's relations with the outside are more practically regarded. The assumption in this study is that they are or should be. Writings on termination (for example Pumpian-Mindlin, 1958) and discharge (Maxmen et al., 1974; Barton, 1975) advise putting emphasis on the patient's ego strengths as the end of treatment approaches, in order to test and encourage the patient in his upcoming encounters on his own.* From the breadth of issues in discharge planning, one would think this strategy would require changes in most aspects of the patient's ward therapy, with staff paying less attention to configurations in ward life per se, but insisting on what the patient

*Footnote. I have seen descriptions of such a shift of emphasis on intermediate or long-stay wards as discharge nears. In my own clerkship on such a ward I noticed how reluctant many of the staff were to set discharge dates for the near future (less than 4 to 6 weeks away), and thought this might partly have to do with the time they felt it would take them to move from an exploratory to a task approach to the patient. Usually the reasons staff gave for delaying discharge were that the patient could not get his discharge work done (find an apartment, a car, a job, a class) in any shorter time.

must do to live outside. For the individual therapeutic dyad, which may have gone deeply into intrapsychic issues, the therapist's responsibility for aftercare referral should be a point of entry for the ward's practical task of helping a patient well back into his dealings with the world.

Edelson offers a theory of group life, which was helpful in planning this project although the questionnaires as they developed do not adopt a point of view that is consistent within his theoretical framework (Edelson, 1970). In Edelson's terms the changes in task discussed above involve the replacement of an autonomous ward orientation vis-a-vis the patient to a heteronomous one -- that is, from concern for the self-sufficient, self-regarding aspect of the patient's personality and his part in the ward system, to concern for how the patient will deal with the outside and how the ward staff will reach into the outside world on his behalf. Another change in perspective also occurs. To the extent that the hospitalized patient was relieved of the need to plan his future, and instead was encouraged to investigate his group behavior and his desires in the protected present, referral work reintroduces the future. Patient and therapist must consider future needs in therapy which future life on the outside (as well as present intrapsychic formations) will create, and which cannot be satisfied until after discharge. In Edelson's terms this change is from an emphasis on "actuality" to an emphasis on "potentiality."

Edelson describes a set of values appropriate to situations where activity that is directed outward and toward the future has primary place. These are the values of "adaptation": cognitive understanding, possession of means that have empirically verifiable relation to whatever ends one

wishes to achieve. Emphasis is on understanding and planning, and obtaining and doing these are in effect the "goals" of adaptational values. The first emphasis in the adaptation group function as applied to referral work would be on achieving a shared understanding of the referral situation according to objective, scientific criteria. The goal would be to learn what arrangements with the Clinic and others would best assure suitable future therapy for the patient, again according to valid impersonal criteria. A further goal would be to learn how to make such arrangements (Ibid., pp. 59-60). Coming to know what a suitable kind of future therapy would be and why should be part of reaching this shared understanding. A number of other elements in the referral situation should also be investigated and a shared knowledge of them achieved such as: basic information about the patient's discharge; his history in outpatient treatment; his motivation for treatment and his understanding of why he might want it and what kind he believes would be best; similar information about how the therapist sees the patient's needs and the kind of treatment he should have; questions about how the Mental Hygiene Clinic should be contacted and what they need to be told; questions about what role the patient's family or close friends might have in his treatment and whether speaking with them would help; and finally, an awareness on the part of both patient and therapist of what the other thinks is important and should be done and of what the other has done or plans to do. In this model, the task of referral asks patient and therapist to look for this knowledge and to talk to each other about their findings. The outcome of this learning and talking could be a more shared set of conclusions about what will get the patient the future treatment he needs.

It would seem, however, that while an adaptational perspective on these issues may represent the work of some therapists, who are students and interested in learning the objective validity of what they do, it would not describe the regular orientation of many patients. They are likely to be concerned about getting help, about what will make their lives on the outside tolerable and better, what will keep them from psychic disorganization and rehospitalization, from family battles and other destructive behavior. Some may be theoreticians of these services but all are also consumers. They are likely to be worried, at discharge, about losing the life they had on the ward. The beginning of referral work extends the context of therapy for many into outside life, but ends therapeutic relationships on the ward. For some pairs of patient and therapist, the demand posed by referral work that the dyad turn to understanding the MHC, the means of obtaining therapy, and the therapeutic means that might suit a patient best after discharge, would be a hard demand to meet if it were attempted in a purely adaptational manner. Referral work might have to coexist with and be influenced by a number of termination problems centered in the dyadic relationship, and by other termination problems having to do with the patient's loss of ward membership. The emphasis in referral discussions on how to contact the MHC or the patient's family, what information to give them, and what kind of therapy would be best, while possibly involving adaptation values, might equally involve intrusive questions of whether the patient trusts his therapist; or questions of the ultimate meaning of continuing as a patient after discharge; of the carry-over from inpatient experience of norms and behaviors relevant to being a patient in the Clinic; of how

the patient can feel like a respected member in a new treatment relationship; or of how reassuring and available the therapist can seem during this time. These perspectives involve other group values discussed by Edelson, in addition to adaptation. Edelson in fact is interested in studying strains set up when two or more fundamental value orientations occupy the same group setting, and it would be possible to talk about axes of strain in the patient-therapist-ward relationship around referral work. However, since the questionnaires as written do not allow for referral to be consistently investigated on this level of theory, the present discussion will not remain with this point.

As described so far, referral work confronts patient and therapist with the need to make inquiries and take actions in several areas; and all of this is a complex situation where no single set of values is likely to be respected in all questions. For this reason, and reasons of time and opportunity, a patient and therapist will not be able to do all the work they might on referral. What the hypothesis of this project uses as its independent variable -- the amount of agreement between descriptions of referral issues and referral work given by patient and therapist -- is in part an attempt to operationalize the concept of the thoroughness of the referral work because this work is seen as producing shared information and understandings as it progresses. (This is perhaps where the adaptational perspective of this view is most evident.)

By the time of discharge, a patient and therapist (or one or the other of them) might have just begun to learn about how the MHC can be contacted and what kind of information it may need. They might not yet know very much about the role of the patient's family in his aftercare. Each might not know what steps toward aftercare the other thinks are

important, or what the other wants aftercare to be. Either may not have discovered any preferences within himself, or any rationale for alternative approaches. Or they might have learned about their own and each other's beliefs and feelings, but not have come to a reconciliation of their views. Some patients and therapists may think it important that they agree upon one choice among several possible recommendations to the MHC, or among several actions toward guaranteeing treatment transition. Others may not value such an integrated approach. In this model, making a referral involves exploration, takes time, and may be more or less completed by day of discharge. But the group work comes to an end and then, since the patient will generally not be speaking with his therapist about it again. In assessing the amount of agreement between the descriptions of referral matters given by patient and therapist at the time of discharge, this project can be thought of, in a general way, as trying to see how far they went with their work. Among all the possible actions listed above, some involve seeking and gathering information from the other member of the dyad, from the MHC, the family, the experiences of others; some involve caring or not caring about the importance of understanding such aspects of the situation; others relate to acting on behalf of referral (talking to the MHC or the family); and some have to do with therapist and patient's discussing and negotiating around choices that come up in the referral procedure.* One notion of judging how far a patient and therapist had gone in this work would be to see how much of these kinds of work they had done. Another would be to see whether they

*Footnote. These four kinds of action correspond to Edelson's categories of adaptation, motivation, consummation and integration respectively.

had dealt with strains arising from conflicting values. No particular ideas of time and development enter in here. This is rather an extensive definition of what makes a complete referral. Another notion would rank referral work in a temporal "developmental sequence" (Tuckman, 1965) believed to apply to task groups. Basing his theory primarily on his own "biases...and [on] the perception of trends in the studies reviewed" (Ibid., p. 386), Tuckman describes four sequential stages in small groups in relation to how they approach a task. The first stage, "orientation to the task," involves making initial definitions and discovering "ground rules." The second, "emotional response to task demands," involves resistance to the kinds of personal reorientation the task may seem to require. In the third stage, "open exchange of relevant interpretations," the group members share information among themselves, including information about their personal reactions to the task. Last comes the "emergence of solutions," emphasizing objectively constructive action. There is a great deal of overlap in the phenomena they order between this and Edelson's description, for example, though the two notions of completeness are different.

The questionnaires written for this project are a sampling of the questions that might be asked of any patient and therapist at discharge. Many referral issues are not covered or briefly touched on. The organization of the questionnaire by subject areas will be described in the next chapter, where a number of dimensions are defined into which the questions can be divided. These dimensions derive mainly from a common sense analysis of the areas of work that referral should deal with. The group theory considerations of this chapter were used to help enlarge the view of each of these areas. Although this chapter has dealt with

theories of complete group work to gain some notion of how far referral work went, the research project presented in this thesis will not attempt the very difficult task of giving explicit rankings for completeness according to theoretical guidelines. Most of the scores that will be developed for a patient-therapist pair are computed from questions that cut across both extensive and developmental categories. The scores are meant to measure how much agreement a patient and therapist achieved in a given area (dimension) of referral work. "How much" is a notion of completeness that, in the present work, has not been closely and explicitly tied to its theoretical basis.

Two further issues related to the model will now be briefly discussed. The first has to do with some sources of variation in the completeness of the referral work done by various patient-therapist pairs. One might expect that the patient's psychopathology would affect what it was possible to do. A patient who at discharge was still so troubled in reality-testing that he could not perceive his clinician's opinions or acts, would not be likely to describe referral as his clinician did. And with a very ambivalent patient, a clinician might not be able to reach any agreement about aftercare. The history of the patient-therapist relationship might also limit what could be done. If it had been operating on values very different from adaptational ones with great emphasis on transference and dependency the transition might be full of strain. A third source of variation would certainly be the attitude of patient and therapist toward their proper roles in what might be seen as a professional matter. Pumpian-Mindlin (1958) notes that transferring a patient, contrasted to terminating treatment entirely, is often seen as a more passive, less challenging process by both patient and therapist.

Similarly, the way in which the patient perceived alliances at referral time might affect his will to participate. If he saw himself as a patient among patients transacting with an inpatient therapist and an outpatient clinic who seemed powerfully bound together in "the system," he might be satisfied with little participation. On the other hand, if he felt that he and his therapist, in a particularly close relationship within the inpatient setting, were negotiating with a very separate and foreign Clinic, he might become quite active. These are a few of many sources of variation, and the difficulties they present in this project will be discussed further in later chapters.

The second issue is this: why imagine that differences between various referrals in the light of this model, should be related to patients' appearing or not appearing for aftercare? One might argue for example that patients came or did not come because of their pathology at discharge, or because of their overall experience of individual psychotherapy, or because they had certain patterns of compliance with appointments made for them by representatives of large institutions like the VA. The discussion above suggests that each of these factors might also affect the referral process. This clearly adds to the difficulty of interpreting any correlation between referrals (evaluated on the basis of the model) and aftercare appearance.

These objections are all legitimate* and like those above, will have to be discussed with the problem of experimental controls in a later chapter. For the present it must suffice to point out why referral process

*Footnote. Note however that except for the general factor of diagnosis (schizophrenic vs. other categories; or psychotics vs. mentally retarded) none of the particular factors mentioned above have been found related to aftercare appearance in the literature reviewed in the first chapter.

and aftercare appearance might be related, independently of such third factors. One reason of course is that without thorough discussion and planning, the patient might at discharge be confused about what aftercare will be, how and when it will begin, who will do it, and why he should bother to come. One can also argue that even patients who see themselves as lacking clinical judgement or organizational power, and who tend not to want an active role in many treatment or ward decisions, might feel differently where what is at issue is a changeover as marked as discharge and referral. Research with groups in industry (reviewed by Heslin & Dunphy, 1964) has found evidence for important differences in how much subordinates want to help decide "changeover" issues compared to more routine matters. Referral should be such an issue, in which the patient's welfare is significantly affected.

Two other reasons for supposing that completed referral work would make patients more likely to come to aftercare have to do with referral as a part of the termination of individual psychotherapy, and with the sociotherapeutic effect of a completed adaptational function. Without going into either at any length, one might expect that fairly solid referral work, with its requirement that as their final task patient and therapist emphasize an orientation to the outside world and a reintegration of the patient with therapy, might mitigate the separation anxiety many patients feel at discharge. A pre-discharge meeting with a clinic therapist would help too. In the sense of sociotherapy, the results for example of the adaptational aspect of referral work well performed should be (for the schizophrenic, for example) less indifference to reality demands, less secretiveness, more knowledge, and a less autistic, more rational approach to problems of how to discover and acquire what one

needs and wants (Edelson, op cit., p. 18). These orientations, and the satisfaction with them, might be expected to make the patient more disposed to coming to the aftercare he had helped arrange.

CHAPTER THREE: PROJECT RESEARCH DESIGN

I. Questionnaires

This project uses original patient and clinician questionnaires as the instruments for gathering information about referral work (see Appendix, pp. 110-117). In keeping with the general strategy of comparing patient and therapist's views of referral, the questionnaires were constructed largely in parallel: that is, both questionnaires contain similar questions about the same material. The wording of the questions addresses them to either the patient or to the therapist. As far as possible questions about the same material have the same number on each questionnaire.

The questionnaires were written to cover a fairly large number of subjects in some detail, while requiring five minutes or less for busy clinicians to complete. The subjects covered are listed below with a brief description of each:

Information:	objective questions not related to acts or preferences of patient or therapist in their current referral work.
Discharge:	objective and subjective questions about preparations and readiness for discharge.
Outpatient Treatment:	objective and subjective questions having to do with general aftercare concerns.
Mental Hygiene Clinic Contact:	objective and subjective questions about matters specifically related to apprising the MHC of this referral and advising the MHC about patient and treatment.
Significant Others:	objective and subjective questions about matters specifically related to discussing aftercare with family or friends who play important roles in the patient's life outside the hospital.

Principles:	questions asking patient and therapist for assessments of the patient's current situation and of his needs.
Clinician's Wishes of the Patient:	questions about what the therapist would like the patient to do in arranging or complying with aftercare.
Patient's Wishes of Clinician:	questions about what the patient would like the therapist to do for him in arranging aftercare.
Clinician's Acts and Plans:	questions about what the therapist has done or plans to do in arranging aftercare.
Patient's Acts and Plans:	questions about what the patient has done or plans to do in arranging aftercare.

The patient and therapist questionnaire items compared in each of these subjects or "dimensions" are listed in the Appendix, pp. 120-129. Some questions, as may be seen, fall into more than one dimension.

Six questions (numbers 7, 11, 14, 17, 22, 24) on each questionnaire are meant to have a screening function in addition to their role as items of comparison. As screening questions, they ask about such things as availability of transportation for the patient to return for aftercare, the patient's intent to look elsewhere for care, and whether the patient and therapist expect the patient to come to the MHC for aftercare. Their purpose is to detect patients who, on the basis of these obvious measures, should be considered poor risks for appearing at the MHC after discharge. It was thought that data on such patients might be stratified together when results were analyzed. The small sample N prevented this however. Responses to the screening questions will be discussed in Chapter Four.

Some questions are subordinated to others in that whether they are asked depends on the answer to a previous question or questions. For example, question #7 on the patient questionnaire, "How long ago were you

in treatment at the MHC?" is asked only if the patient has answered "yes" to question #6, "Have you ever been in treatment at the outpatient clinic here before?" Questions #42-57, all pertaining to significant others, are asked only if the patient replies to #41 by saying he does have family or friends who are important to him and whom he will be seeing after his discharge. Subordinated questions are listed in the Appendix, p.135 . The inclusion of questions like these means that patients (and therapists) will answer different numbers and combinations of questions overall.

In terms of the kind of answers they require, questions are of one of three types: the largest number are answered "yes," "no," or "don't know"; nine patient and eight clinician questions are answered by marking one of five spaces on a rating scale with labeled extremes; and fourteen questions on each questionnaire ask for write-in answers. So that patient and clinician answers to these latter fourteen can be compared, answers are coded in categories (for the categories, see Appendix, pp.136-137).

Scoring the questionnaires involves comparing patient and clinician answers to parallel questions and scoring them either "agree," "disagree," or "don't know." Items which were not answered by patient or clinician or both are not scored. Items are scored "agree" if (a) the answers agree exactly and are not "don't know;" or (b) for rating-scale comparisons, if patient and therapist answers fall both on the same side of the midpoint, or both on the midpoint (that is, in scoring, the five-point scale is contracted to a scale with three points). Items are scored "don't know" if patient or therapist or both answer "don't know." All other results are scored "disagree."

Each patient-therapist pair is given three summations for each of the ten dimensions listed above. These summations are:(1) the number of

agreements on dimension items; (2) the number of don't know results; (3) the number of disagreements. The ratio of agreements to total questions scored (agreements plus disagreements plus don't know results) is calculated and used as the principle score for the dimension. The same summations and agreement ratio are obtained for each patient-therapist pair for the "dimension" of the entire questionnaire. (See Appendix, p. 135 for a list of all the items scored.)

In addition to the ten dimensions described above, a dimension was defined for the patient and clinician questionnaires separately which did not involve comparing patient and clinician responses. These two dimensions are:

The Good Patient: questions on the Clinician Questionnaire having to do with whether the clinician thinks the patient will behave in ways the clinician finds desirable.

The Good Clinician: questions on the Patient Questionnaire similarly having to do with the clinician's compliance with the patient's notions of what the clinician should do.

Items in these dimensions are listed in the Appendix, pp. 131-132.

It is important to notice that the ten agreement dimensions and the two unilateral dimensions mean to describe different territories in the work of referral: not just different subjects of discussion between clinician and patient (such as MHC. and relations with family), but different aspects of their interaction. Their being aware of what the other has done, what the other plans to do, what judgements the other makes, what the other thinks one should do are all covered in individual dimensions. An objection might be made to correlating agreement on items like question #31 ("Do you think your clinician does plan to talk more with the outpatient service about your referral and treatment there?")

with the patient's inclination to attend at the MHC. A patient who answered "yes" to this question even mistakenly might be thought more likely to come than if he knew that his therapist considered his work finished. The use of multiple dimensions is partly to check whether such a view is supported by data. For that reason, all questions of this type are collected in the dimension "Clinician's Acts and Plans," where the correlation of agreement with attendance can be independently checked. Similarly, the unilateral dimension, "The Good Clinician," tests whether a patient's attendance is related to his reporting beliefs that his therapist has done or plans to do what the patient would like him to do. In this way the project design attempts to consider the idea of "agreement" critically where such consideration seems called for.

II. Universe and Sample

The sample was selected from among all inpatients on G8W, G8E, and G7E (the intermediate and short-stay psychiatric wards at the West Haven Veterans Administration Hospital) who at discharge were newly referred by their therapists to the Mental Hygiene Clinic of the hospital. In order to be considered "newly referred," they must not be simply referred back to an MHC clinician or group with whom they had been in treatment at the time of their current admission. The referral must be for a new aftercare plan.

The sample was defined as all such patients discharged between October 30, 1978 and December 15, 1978 (seven weeks). In order to identify this sample, the head nurse on each of the wards was contacted between three and five times each week (from one week before the study began

through the last week) for the names, clinician assignments, and discharge dates of any patient who was to be discharged (or had been discharged suddenly) with a new MHC referral. In cases where the head nurse did not know these details of a discharge, the patient's clinician was asked whether a new MHC referral was to be made. Patients with planned discharge dates who were on the ward were interviewed by the researcher for completion of the questionnaire as close to the time of discharge as feasible, usually on the day of discharge but several times the day before. Telephone interviews were attempted with all patients who were missed on the ward. Therapists were asked, usually by note, to complete a Clinician Questionnaire. In cases where a patient could not be contacted by phone within ten days of discharge, and where a clinician did not complete a form within ten days of discharge, no further attempts were made to collect questionnaire information. It was felt that inaccuracies of memory would invalidate data collected after that time.

III. Administering the Patient Questionnaire

The interview plan called for the researcher and patient to meet privately in order to go through the patient questionnaire. The investigator introduced himself as a medical student doing research on the psychiatric wards, gave the patient a copy of the Informed Consent statement and read it to the patient (see Appendix, p.138). This statement includes a brief explanation of the project and its purpose. Confidentiality of the patient's answers was emphasized. No patient refused to participate. After consenting to participate the patient was given a copy of the Patient Questionnaire and the investigator read the questions

to the patient together with the answers (if any) provided on the questionnaire. With rating scale answers, the investigator read the extreme answers, added "or somewhere in between," and noted that there were five spaces covering the range between extremes. Some patients preferred to record their answers on their copy, but most wanted the investigator to record answers on his copy.

Certain questions were frequently not understood at first reading. If the patient said he did not understand, the investigator slightly rephrased the question or explained it. This happened with the following questions, which are given here together with the explanations or rephrasings used.

#10. What kind of outpatient treatment do you think would be best?

Explained as: one-to-one, group, couples, family, or medication therapy (the range offered at the MHC).

#26. Would you feel better or worse about beginning outpatient treatment if you knew your present clinician had given the clinic some information about you and the reasons for your treatment?

Rephrased: "...if you knew your clinician had told the clinic something about you and why you needed outpatient treatment."

#27. Would you feel better or worse about beginning outpatient treatment if you knew that your clinician had given advice about your outpatient treatment?

Rephrased: "...given advice about what kind of outpatient treatment you should have?"

Patients were not pressed to answer quickly, and many talked at some length about themselves or their attitudes about therapy and psychiatrists. Nevertheless it was possible to end most interviews within twenty minutes.

The investigator had no contact with clinicians regarding questionnaires except to request that they complete one for each patient included

in the study. Clinician Questionnaires were collected as the study went on but were not looked at (except to check them off as complete) until the data-gathering phase ended. The investigator did not look over Patient Questionnaires until all data was collected, except to write down interesting patient comments which were not answers to questions.

IV. Introducing the Project to the Wards

The three inpatient wards were informed about the study at two different times. A presentation of the first version of this project was made at ward staff meeting on each ward, and copies of the Clinician Questionnaire for that version were distributed together with several pages of guidelines to clinicians for answering the scale ranking questions. Because of time pressures this meeting was not repeated on two of the wards (G8E and G8W) when the second version of the Clinician Questionnaire was introduced. Instead, all clinicians were given a copy of the questionnaire and a note explaining that revisions had been necessary in the study and that the old questionnaires were superceded.

In both the ward meetings and on the information sheet distributed with the second version of the questionnaire, clinicians were told that the study would not be used in any way to evaluate their performance in making referrals.

CHAPTER FOUR

I. Sample

Twenty-seven patients qualified for inclusion in the study. One was interviewed but excluded from the study because his clinician was off the ward for the two weeks prior to his leaving against medical advice. One could not be included because his clinician did not complete a questionnaire. Six patients were not interviewed prior to discharge and could not be interviewed by phone within ten days. One additional patient was interviewed but excluded from the study because he was readmitted the Monday following his Friday discharge.

Nineteen patients made up the study group. Of these, sixteen appeared for aftercare in the Mental Hygiene Clinic and three did not. Of the eight patients who qualified but were not included, six did not attend aftercare and two did. Thus sixteen of eighteen patients who attended are included, but only three of nine who did not. This means that the results to be reported are fairly heavily biased towards patients who appeared for aftercare.

Five study patients were service-connected for outpatient treatment; one of these did not appear for aftercare. Neither in the study group nor in the larger group of twenty-seven patients was there a significant ($p < .05$) correlation between service-connection and appearance for aftercare.

Table 5 lists the twenty-seven patients and their study status, ward of origin, and outcome status. Ward 8W is represented in the study by eleven of fourteen qualifying patients; 7E by six of eight; ward 8E by

TABLE 5

SAMPLE DATA

PATIENT	INPATIENT WARD	OUTCOME	STUDY STATUS
1	8W	A	Included
2	8W	A	Included
3	8W	A	Included
4	8W	A	Included
5	8W	A	Included
6	8W	A	Included
7	7E	N	Included
8	7E	A	Included
9	7E	A	Included
10	8E	N	Included
11	8E	A	Included
12	8W	A	Included
13	7E	A	Included
14	7E	N	Included
15	7E	A	Included
16	8W	A	Included
17	8W	A	Included
18	8W	A	Included
19	8W	A	Included
20	8E	A	Not included--clinician absent prior to discharge.
21	8W	N	Not included--no clinician question- aire.
22	8W	N	Not included--missed.
23	8W	N	Not included--missed.
24	7E	A	Not included--missed.
25	7E	N	Not included--missed.
26	8E	N	Not included--missed.
27	8E	N	Not included--missed.

two of five. Thus there is a second bias against 8E in the results of this study.

II. Data

On initial analysis of the questionnaire data it appeared, as expected, that the number of patients and clinicians answering an item varied from item to item. However, subordination of one question to another was not the only reason for a question to be left blank. Only four patients were able to understand and answer questions 15 and 16, so these questions were dropped from further consideration. Patient questions 34 and 35, both subordinate to question 33 ("Have you and your clinician talked over what he/she might tell the outpatient clinic about you?") were answered one and no times, respectively, because only two patients answered question 33 affirmatively. Therefore, they were dropped as well, although the therapists' responses to question 34 which will be discussed with the MHC dimension. Questions 24 and 25, asking about the patient's plans to continue seeing his inpatient therapist and inpatient ward staff, was not considered further because it would have required a more specific description of the kind of contact the patient expected to have. Question 9 (P: "What would you like to get from outpatient therapy?" C: "What is the main problem for which this patient will need treatment?") will also not be considered for agreement scoring because of lack of parallelism in the two versions.*

*Footnote. After data-gathering was under way it came to the investigator's attention that the work of Lazare and Eisenthal (for example, Lazare et al., 1975) offers a better guide to questioning both patient and therapist about what the patient wants from treatment. Questions in a project like this present one could be rewritten to adopt their categories of inquiry.

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Several open questions frequently elicited more than one answer, and these questions are given two scores (for two answers) which are treated as independent items. Medication (question 19) is one of these. In comparing questionnaires for agreement scoring, care was taken to credit every agreement; that is, if both patient and therapist mentioned lithium carbonate, it was recorded in corresponding spaces on both questionnaires so that the agreement would register. Other two-answer items were handled in the same way (they are items 10, 13, 19, and 42; and item 9 which as noted above was not included in agreement scoring). If the patient gives two answers and the therapist one, an additional answer of "don't know" was assigned to the therapist; and similarly if the therapist gives two answers and the patient one.

Problems of incomprehension (as with questions 15-16) or unwillingness to respond affected other patient questions sporadically. Therapists occasionally failed to respond to an item in a context which allowed no construction of their reason for not answering; and a number of therapists did not answer certain questions in the group on significant others because they felt they were not the clinician responsible for speaking to the patient's family or friends. In two cases, of this kind, the answer "don't know" was filled in for questions 55 and 56; the same two therapists were scored "no" on question 53; and one was scored "don't know" on question 50.

These were the only cases where answers were entered for missing data. Because of the preliminary nature of this study and the small number of patients and therapists included, it was thought to be inappropriate to replace missing data by means of a formal overall strategy. In

calculating agreement scores for patient-therapist pairs for the dimensions and the whole questionnaire, the strategy decided before data were collected was retained. The score for a patient-therapist pair, therefore, is the ratio of questions agreed upon to total questions answered by both individuals. The assumption involved is that the reason for grouping questions in a dimension is strong. The Appendix contains on page 135 a ranking of agreement items by score, showing points of division for the 33rd and 67th percentiles.

The median agreement ratio score for all items is 58.6% and the mean 57.9%.

For each patient-therapist pair, Table 6 gives the total number of items that could be scored for agreement, and the agreement ratio score for these items. The scores range from 32% to 77% agreement with a median of 63% and a mean of 60%.

Tables of the agreement ratio scores for each patient-therapist pair on each of the dimensions are given in the Appendix, pp. 120-129. Testing of these scores for association with appearance for aftercare will be described later in this chapter in the section on correlation.

III. Introduction to Questionnaire Results

In the following discussion, questions on the questionnaires are referred to by their numbers whenever they are being considered singly. When reference is made to the patient-therapist agreement score for a pair of questions (the score being either "agree," "disagree," or "don't

TABLE 6

TOTAL ITEMS SCORED AND % AGREEMENT BY PATIENT-THERAPIST PAIR

PATIENT	# ITEMS SCORED FOR PAIR	% AGREEMENT
1	49	71.4
2	39	59.0
3	51	68.6
4	48	58.3
5	34	52.9
6	50	64.0
<u>7</u>	36	52.8
8	52	48.1
9	48	70.8
<u>10</u>	31	35.5
11	48	54.2
12	49	63.3
13	44	50.0
<u>14</u>	37	32.4
15	48	68.8
16	50	68.0
17	52	76.9
18	49	69.4
19	25	76.0
mean		60.0
median		63

TABLE 7

DIMENSION	MEAN AGREEMENT SCORE	MEDIAN AGREEMENT SCORE
Information	69.7 %	70 %
Discharge	68.8	85.7
Outpatient Treatment	65.8	72
Mental Hygiene Clinic Contact	49.7	50
Significant Others	62.3	63
Principles (augmented)	53.3	57
Clinician's Wishes of Patient	65.8	71
Patient's Wishes of Clinician	(not scored for agreement)	
Clinician's Acts and Plans (augmented)	61.2	64.5
Patient's Acts and Plans	65.5	71.
All agreement items	60	63
	MEAN FAVORABLE RESPONSE	MEDIAN FAVORABLE RESPONSE
The Good Therapist	64.8	67
The Good Patient	60.9	64

know") the pair of questions is called an item," and is designated by a single number if that number is shared by both the patient and therapist's questions, or by a notation like "P10-C13" if the two questions do not share a number. This would then mean that patient question 10 is tested for agreement with clinician question 13. Most items are of the former kind; "item 10" for example being the common shorthand for "item P10-C10." It is hoped that this will not be confusing at least in context.

The kinds of analysis of data that could be presented are limited by the small sample number and the high number of possible responses to most questions and items. The majority of questions give three choices for answer and most of the rest give more. When the varieties of patient and clinician paired answers are examined, they are almost always more; of course nine varieties are possible for questions with three responses. The situation is improved somewhat by "collapsing categories," as is done for example in agreement scoring, where all manner of actual pairs of patient and therapist responses become examples of one of three scores. The process is repeated in summing items for agreement and lack of agreement to arrive at the agreement ratio score for a dimension. In the following discussion the freedom will be taken to talk about data in its original form as patient and clinician answers, and in the form of various categories. Because of the problems of numbers mentioned above, significance tests will not be applicable to much of this discussion, and this is true both when questionnaire data is being compared with outcome, and when a sketch of the referral process is being built up by comparing responses to one question with those to another.

The statistics of one specific kind of comparison of data will be discussed briefly here. In describing the referral process, it will

any) the same as the one which is called

single in the first part of the

question, and the same as the one

which is called in the second part of the

for the same reason, and the same as the one

which is called in the third part of the

it is the same as the one which is called

in the fourth part of the

by the same name, and the same as the one

which is called in the fifth part of the

for the same reason, and the same as the one

which is called in the sixth part of the

of the same name, and the same as the one

the same as the one which is called in the

for the same reason, and the same as the one

which is called in the seventh part of the

the same as the one which is called in the

of the same name, and the same as the one

which is called in the eighth part of the

for the same reason, and the same as the one

which is called in the ninth part of the

the same as the one which is called in the

of the same name, and the same as the one

which is called in the tenth part of the

for the same reason, and the same as the one

which is called in the eleventh part of the

frequently be said that the number of agreements on a particular item was, say, sixteen out of nineteen scores, or nine out of twelve; or it will be said that only three out of nineteen patients answered "yes" to a question. The most ready notion of the statistical significance of such descriptions (that is, of whether or not the described results would probably be much the same in any similar sample of patients and therapists at discharge) is to compare the result with what would be expected if chance alone decided the answers of patient and therapist to the questions. If it is assumed that choosing answers is random in this sense, the likelihood of any given answer depends on how many answers there are to choose from, each being equally probable. Almost all questions on the questionnaire have at least three choices. If the probability that patient or therapist might give a certain answer is one-third it can be determined by chi-square testing that eleven or more answers of one kind on a question answered by all nineteen subjects differs from chance at $p < .05$, and that two, one or no answers of one kind is similarly significant. Where agreement scores are concerned, the chance of agreement on an item composed of two three-choice questions is two-ninths (22%). This is 4.18 agreements out of nineteen scores, for example. If an item has nineteen scores, and if the number of chance agreements out of nineteen is slightly exaggerated (5 rather than 4.18) a chi-square test can be done on the actual distributions of agreement and lack of agreement. It turns out then that agreement rates of $\geq 47.4\%$ (9 agreements) or of $\leq 5\%$ (one agreement) are significantly different from the chance result at $p \leq .05$. With items having fewer than nineteen scores, using the chi-square test discriminates progressively more against finding a result

significantly different from chance, because while the actual number of agreements obtainable by chance declines, the test requires that it be held constant at 5. The most that can be said is that 9 or more agreements on any item is a chance result at $p \leq .05$; but this is an artificially high requirement for all items, worse as the number of patient-therapist pairs scored for an item decreases.

This problem does not arise in differentiating overall dimension agreement scores from chance, because many more item scores are involved. The percentage of agreements expectable by chance varies from dimension to dimension according to the type of questions that compose the dimension, but on all it would be less than the 22% given above for the single three-choice question. On the MHC Contact dimension, for example, where there are 194 item scores, the mean agreement score for the dimension is 49.7% or about 96 agreements compared to the 43 or fewer expectable by chance. The dimension score is significantly different from chance at $p < .001$ (one-dimensional chi-square test); so are the others.

Most of the presentation of results and the discussion that follow aims to characterize referral work for the present sample of patient-therapist pairs. Where statistical significance for a result is not explicitly explained and claimed, it is not to be considered implied. The discussion above offers only a commentary on estimating whether a particular result differs significantly from what one would expect by chance (where chance is considered to be determining patient and therapist's responses to single questions).

Three problems which became evident during the data-collecting are responsible for this skepticism about the usefulness of significance

tests for this data. The first inability to get some of the eligible patients into the study has been discussed already. A second problem arises from the fact that patients and therapists did not complete questionnaires at the same moment. A patient who says his therapist has not given the MHC enough information (by the day of discharge, for example) to help his referral go well (question 29) might be in agreement with his therapist at that time. If his therapist does not answer the questionnaire for several days and in the meantime contacts the Clinic again, his answer will be likely to change, and a false disagreement will register when the patient's questionnaire is compared with his therapist's. A third problem, also caused by not having the two questionnaires completed at the same time, is a problem of feedback. A number of patients saw their therapists for the last time after completing the patient questionnaire. Should their discussion have been influenced by issues raised by the questionnaire, information and feeling might be exchanged which would cause the therapist, when he filled in his questionnaire, to answer differently than he otherwise would have, and this would destroy the independence of the patient's and clinician's answers. Although this study means to examine shared information, the sharing that is measured should be independent of the effects of completing the questionnaire. Feedback clearly is not.

It is impossible at this point to say how active these last two factors actually were in modifying the results of the study, and these results will be discussed as if the modification were not serious. The reader will want to keep in mind though that the workings of these factors could have extensively affected certain results.

IV. General Referral Situation

The responses to selected questionnaire items can tell something about the basic orientation to aftercare and basic customs of the

referral work, as perceived by patient and therapist. In answer to #9, "What would you like to get from outpatient therapy?" seven patients described an element of the therapy process, such as "support," "stress release," "counseling," or "encouragement if I'm in trouble." Five patients named a treatment goal, such as overcoming problems with parents, learning to live independently, or achieving self-understanding. Five patients stated their complaint or their psychiatric diagnosis (for example, "agoraphobia," "depression," "suicidal feelings") and said they wanted help with that. Four patients said they wanted medication, or help with "nerves" (the complaint of "nerves" was always associated with wanting medication by patients in this sample and so the two are regarded as a single category here). A single patient wanted help with alcoholism, and two did not know what they wanted from outpatient therapy. Except perhaps for the last three, all of these responses suggest that the patients want something which the MHC means to be able to provide.

In answer to question 10 patients named six categories of outpatient treatment as "best." Ten mentioned individual psychotherapy; couples, group, and medication group or clinic were named three times each; therapy with the present inpatient therapist, and an unspecified kind of "talking" or "counseling" were each named twice; and one patient did not know what kind of therapy would be best. Although a minority of patients mentioned medication or medication group in answer to questions 9 and 10, fourteen patients said their clinician advised them to take medications as outpatients (question 18) and all of these planned to take this medication (question 20). Thus, although 14 of 19 patients planned to continue on medication and to get it through the MHC (question 21), only three or four thought medication should be the defining characteristic of their aftercare.

Most studies of discharged patients have not explored whether those who failed to keep aftercare appointments eventually found treatment elsewhere (but see Chameides et al., 1973). In this sample, all nineteen patients said they planned to come to the MHC for treatment. Fifteen patients said they did not plan to seek treatment elsewhere. One patient said he might look for treatment in his "hometown" (not further specified); one mentioned another mental health clinic closer to his home; and one said he might go to a private medical physician for somatic complaints. One patient did not know whether he would look elsewhere.

The modal patient at discharge, therefore (as reported by the patients) prefers a mode of therapy, and has treatment needs that are compatible with what the MHC provides. He will be on major psychoactive drugs but does not see medication as the main aspect of his aftercare. Finally, at discharge he has no plans to look elsewhere for therapy.

Given this general orientation to aftercare on the patients' part, to whom do they give responsibility for their referral? In answer to questions 26 and 27 ("Would you feel better or worse about beginning outpatient treatment if you knew your present clinician had: (26) given the clinic some information about you and the reasons for your treatment? (27) given advice about your outpatient treatment?"), fifteen patients thought they would feel better if the therapist gave information, and eleven if he gave treatment advice. Four patients gave a neutral response to question 26 and four to question 27. One said the giving of treatment advice would make him feel worse. On the other hand, only two of nineteen reported that they and their clinician had discussed what the clinician might tell the MHC about the patient (question 33). (One

patient suggested at this point that the questionnaire should also ask whether patients wanted to discuss such things with their clinicians. His answer, he said, would be yes.) Only six patients said they had talked to someone from the MHC about getting treatment there, and only three (all of them among these six) said their present clinician had advised them to (questions 36 and 38). Seven patients named someone beside their therapist who might help with transfer to the MHC (question 39). Four of these helpers were inpatient ward staff, two were MHC staff, and one was a member of the patient's family (question 40). Ten of nineteen patients had either spoken to the MHC or said they knew of someone beside their therapist who could help them transfer to the Clinic. However, among the seven patients who answered neutrally or negatively to one or both questions about the "therapist's" role (question 26 and 27), only three had either spoken to someone from the MHC or said they knew of a third person to assist their transition. The questionnaire does not try to ascertain what aspects of referral work had been or could be performed (in the patient's opinion) through these contacts.

The majority of patients, therefore, report that they have not contacted the Clinic or been advised to. Most would feel better if their therapist took an active role in their referral, but a sizeable group report themselves indifferent, at least to their therapists' assisting the Clinic in aftercare planning. Few have discussed with their therapist what he might say to the MHC about them. Most of those who are indifferent or opposed to an active role for the therapist in MHC contact do not report any alternative way of communicating with the Clinic. This suggests that in practice as in design, therapists have the essential referral work to do; and that (if done well according to the referral



model of Chapter Two) this would sometimes consist partly of discussing the therapists' role with patients who felt ambivalent about it.

The role played by a patient's family or friends in his appearing or continuing in aftercare has been thought important in some studies, but not fully explored (Raskin, 1968; Baekeland & Lundwall, 1975). Fifteen patients in this sample said they would frequently be seeing people who were important to them. Although fourteen said these people were in favor of the patient's attending aftercare (question 43) five patients said they would not attend if family or friends thought attendance unimportant; and if family or friends opposed their coming five patients said they would not come and one did not know (questions 44 and 45). All of these were among the 12 patients who said they had spoken with family or friends about aftercare (question 46). Five patients thought it important for their present clinician to talk more than he already had with family or friends; eight thought this unimportant (question 53). Among the five were three of those who thought they would not come, or did not know if they would come, against the opposition of family. Question 57 asks whether staff other than the patient's therapist have spoken to family or friends; seven patients said no, one did not know, and six said yes. Question 51 similarly asks whether the therapist has spoken to family or friends about aftercare. Five patients said no and two did not know. Four patients reported that neither therapist nor any other staff had spoken to family or friends about outpatient treatment. Thus, five patients in this sample give a significant role in assuring aftercare to the attitudes of family and friends (the ten who claim independence are probably over-optimistic -- see therapists' rating of questions 44 and 45 below), but the role of the therapist in negotiating with family is

less clear than was his role vis-a-vis the Clinic. Only one-half of the patients thought their therapists had been involved at all in speaking with family and friends, but one-third of the sample said their therapists should have done more than they had done to date. A role for third parties, which might mitigate the need for the therapist, is acknowledged by fewer than one-half of the sample.

Therapists' descriptions of the general orientation to outpatient treatment relations with the MHC will be discussed in a later section. Patient-therapist agreement on the two dimensions, Outpatient Treatment and MHC Contact, from which the questions discussed above were taken, was related to appearance at aftercare, and the kinds of agreement and disagreement on those dimensions will be discussed in the context of outcome correlation. Since this project has a purpose of describing referral work even apart from its relation to aftercare attendance, some account will be given here of how the therapists' answers to questions about significant others compare to the answers of their patients.

All therapists answered questions in this section (questions 41-57) so that three patients who said they would not be seeing family or friends important to them were at variance with their therapists' opinions (one patient broke off the interview before this section was reached). Eighteen therapists judged these important people favorable to aftercare so that in this, their estimate was similar to the patients (13 of 15 agreement). But a marked difference appears in therapists' estimate of the patients' likelihood of attending should opposition develop among these people. Question 44, "Do you think the patient will attend treatment even if these people think it is unimportant?" elicited 6 "no" and 7 "don't know"

replies; the question "Do you think the patient will attend treatment even if these people think he should not?" elicited 9 "no" and 9 "don't know" replies. Only six of thirteen patient-therapist pairs agreed on question 44 (three "yes" and three "no"), and three of thirteen agreed on question 45 (all "no").

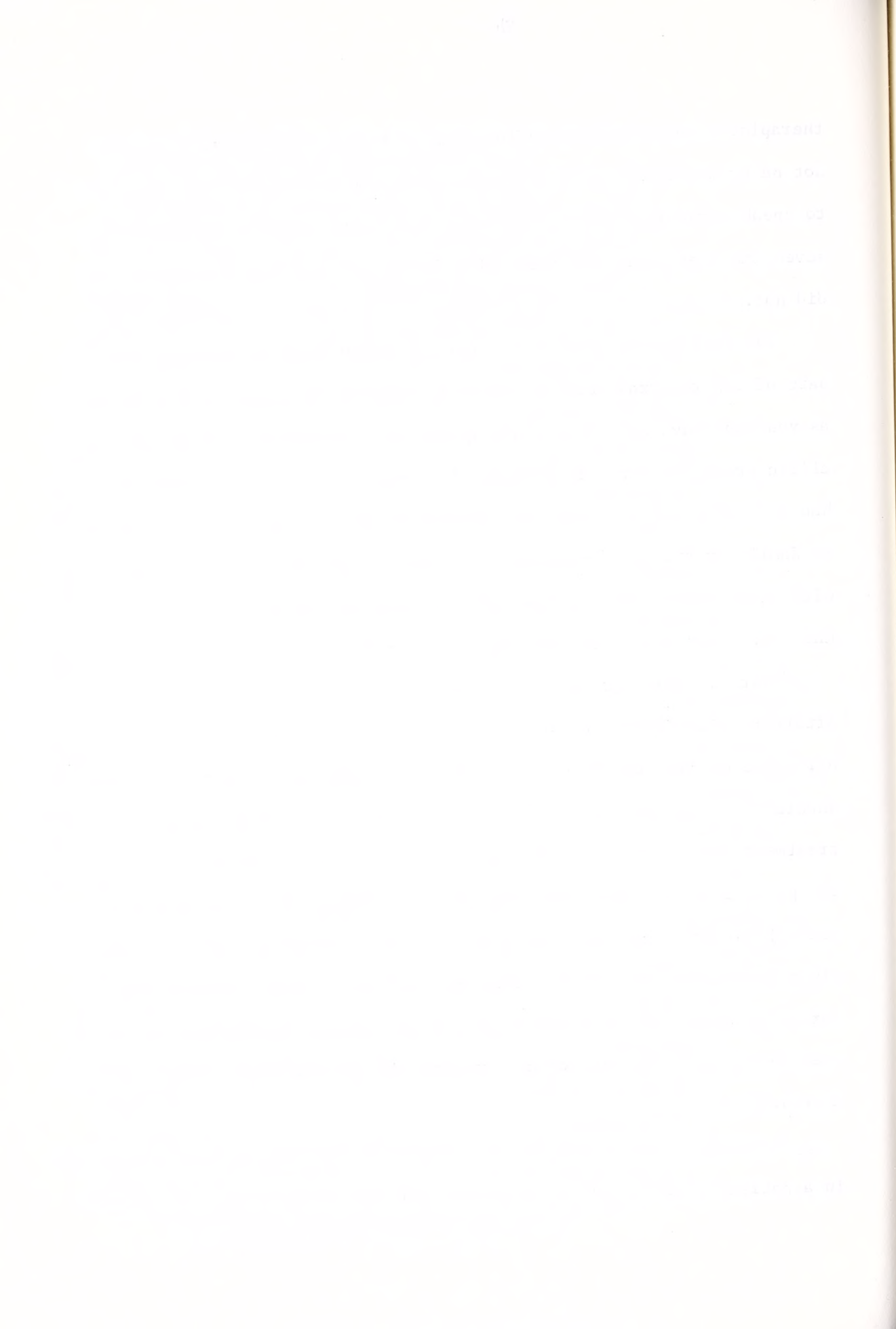
The question of the therapist's proper role in discussing aftercare with families and others is complicated by ward practice. On 8W (accounting for eight of the patient-therapist pairs scored for agreement on this dimension), contacts with family are the duty of other staff or another clinician; nevertheless five 8W therapists said they had spoken with family or friends about aftercare. Apparently the rule does not limit practice. Three 8W patients said they hoped their therapist would speak more with their families, and two of the three therapists were aware of this wish (comparing P53-C55). A simpler measure of the understanding of the therapist's role in practice is whether patient and therapist agree about the therapist's contact with family or friends. Nine therapists of fifteen said they had talked to family or friends and one of these planned to talk more (questions 51 and 53). Eight patients thought their therapists had talked to these people and one more said his therapist planned to (questions 51 and 55). Eight pairs are in agreement about whether the therapist has spoken to important people (six "yes" and two "no"); five disagree; and in one pair the patient does not know. Ten of fifteen therapists say that their speaking to significant others has made, or could make them more favorable to the patient's aftercare (question 50); all ten patients answering the corresponding question also say "yes." Six of nine pairs responding to this question are in agreement that the

therapist's word would be influential; three therapists say it would not be or don't know. Of eleven patients who wanted their therapists to speak more with family or thought their word would be influential, seven had therapists who spoke with family and four had therapists who did not.

The therapists' view of the role of other staff in handling this part of the referral work is partially explored in question 57 ("As far as you know have any other staff spoken with significant others about clinic treatment for this patient?"). Overall, ten thought other staff had done so. Six of these were therapists who had not themselves spoken to family or friends (question 51). Seven therapists said their contact with these people had been the only contact, or the only contact they knew of. Only two therapists knew of no contact with family or friends.

There is good agreement about whether the patient has discussed aftercare with family or friends (eleven agree on "yes" for question 46). Agreement on question 49 (patient: "Has your present clinician said you should talk some more to your family or friends about your outpatient treatment before you leave the hospital?" clinician: "Have you advised the patient to talk more with significant others about outpatient treatment?") is less good, with all twelve patients answering "no" and therapists responding "yes" seven times and "no" five times. However this agreement result may be contaminated by the lack of parallelism in the questions, since the clinician's version did not stipulate "before discharge."

In summary, therapists say that family or friends are more influential in a patient's attendance at aftercare than the patients do. While there



is fairly good agreement that patients have discussed aftercare with these people before discharge, there is agreement only about half of the time over whether the therapist has done the same. Clearly the role of the therapist is less well defined. One reason for this is probably that on two wards (G8E and G8W) different clinicians deal with patient and with family. However this is not the only reason, since most G8W therapists spoke to family and thought their role influential (the G8E sample of two dyads is too small to consider separately). Overall in this sample, a majority of both patients and therapists report that the therapist has participated and that his role with family and others was or would be influential. On all questions of mutual role, patients and therapists tend to agree at a rate close to or slightly better than the mean agreement rate for the whole questionnaire (60%). Nevertheless there are quite a few patients who do not know what their therapists have done or how they see their roles, and there is room for patients to think (accurately or mistakenly, about one-third of the time) that their therapists have not done what they would have them do.

V. Correlated Measures

Four screening questions (numbers 8, 14, 17, and 22) asking about need for aftercare, likelihood that the patient will return for care, availability of transportation to the WHVAH, and patient's plans to seek treatment elsewhere, were regarded as a means for identifying patients at high risk for failing to keep aftercare appointments. For this purpose, patient and clinician answers to these questions were scored separately, yielding estimates of risk based on the patient's self-report and on the



therapist's opinion. The four questions were scored by assigning the value 1 to answers favorable to the patient's returning, 0 to neutral or "don't know" responses, and -1 to answers unfavorable to the patient's returning. These scores were summed over the four questions, giving a single number for the self-report and therapist report. This is obviously a rough procedure. It allows, however, exact statistical comparison of the group of three nonattenders with the group of sixteen attenders. On self-report, the patients scored 4, 3, and 2 (maximum score possible is 4, minimum possible is -4). The likelihood of choosing at random a group of three patients from this sample with scores at least this low is over 40% (see scores and calculations in the Appendix, p.¹⁴⁰). Therefore, from self-report scores one would have little chance of picking out the three patients who are nonattenders.

On therapist report, the nonattenders are scored 4, 3, 1. The likelihood of selecting at random a group of three patients from this sample with scores this low or lower is $p = .12$ (see Appendix, p.¹³⁹). This is a result of borderline significance, but suggests that this may be a high-risk group. More obviously, with such a small group, one should say that the patient scored 1 by his therapist may be thought at risk for non attending. (In this case the low patient score arises from three "don't know" answers given by the therapist. The patient's self-score is 4.)

The statistical test selected for comparing aftercare appearance with agreement scores on the dimensions and on the whole questionnaire is the Mann-Whitney U test (Siegel, 1956). This statistic makes no assumptions about the distribution of the independent variable (agreement score);

that is, unlike the t-test, for example, the Mann-Whitney U test does not assume that the variable is normally distributed over the population (of patient-therapist pairs in this case). It gives the probability that scores of two independent groups (aftercare attenders and nonattenders) have been drawn from the same population of scores. In this case, attenders and nonattenders constitute independent groups because all patients were free to attend or not; and attendance or nonattendance by any patient is presumed not to have affected the attendance of any other patient. The hypothesis of this research is that the population of all patients who do not appear will have a distribution of agreement scores of the population of all patients who appear for aftercare. It is this hypothesis that is tested by the U test. The null hypothesis is that the two patient populations cannot be distinguished by their agreement scores -- that is, that the distribution of scores of both populations is the same.

The U test does not use the agreement scores as such. It requires that all scores be ranked in order, and the order of scores is what enters the calculation. In ranking scores on the agreement dimensions as well as on the entire set of agreement items, one must consider whether small differences in the computed ratio (for example, between a score of 2 agreements out of 5, or .40, and 3 out of 7, or .43) imply a real difference in the "amount of agreement" in the two patient-therapist pairs. The more items that have been scored in a dimension, the more confidence one has that a small difference between two ratios corresponds to a real difference in the amount of agreement. The accepted technique to increase confidence that the ranking of scores corresponds to some real ranking of subjects being scored, is to group scores according to uniform intervals. For example, if few items are involved in a dimension, then one might

group all scores from .00 - .09 and assign them a tied position for the first rank; assign all scores from .10 - .19 a tie for second rank, and so on. This has been done in calculating the U test for the dimensions and the total questionnaire. Interval sizes of either .05 or .10 units have been chosen depending on the number of items scored in a dimension; the larger interval is used for dimensions with fewer items spread over a larger range of scores, and the smaller interval for dimensions with more items spread over a shorter range of scores.* The ranking of patient-therapist pairs by score and by interval is shown in the Appendix, pp. 120-130 for each dimension and for the aggregate of items. The formula for the Mann-Whitney U test and the calculations are shown as well.

Table 8 presents the results of applying the U test to the data of this study. The hypothesis that those who appear for aftercare and those who do not form populations that can be separated by high and low agreement scores, respectively, is supported for the overall questionnaire at a confidence level of $p \leq .01$. Agreement scores on several dimensions also show a significant ability to discriminate populations: Discharge ($p \leq .05$), Mental Hygiene Clinic Contact ($p \leq .025$), Principles ($p \leq .025$), and Clinician's Acts and Plans ($p \leq .01$). The dimension Outpatient Treatment is of borderline significance ($.10 \geq p \geq .05$). Four dimensions are without significance and one (Patient's Wishes of Clinician) was not

*Footnote. It should be noted that the level of significance of a result calculated by the U test varies somewhat according to how scores are ranked in intervals. The possibility that interval ranking exaggerates significance of some results is perhaps partially offset by the tendency of the U test to underestimate significance in all calculations where several scores are tied for the same rank, as they frequently are here.

TABLE 8

DIMENSION	SIGNIFICANCE
Information	n.s.
Discharge	$p < .05$
Outpatient Treatment	$.10 > p > .05$
Mental Hygiene Clinic Contact	$p < .025$
Significant Others	n.s.
Principles (augmented)	$p < .025$
Clinician's Wishes of Patient	n.s.
Patient's Wishes of Clinician	n.s.
Clinician's Acts and Plans	$p < .01$
Patient's Acts and Plans	n.s.
All agreement items	$p < .01$
The Good Therapist	n.s.
The Good Patient	n.s.



tested because of the low number of agreement scores obtained for its items. All significance levels hold for the specific prediction not only that scores for the two populations will be different, but that scores for the nonappearing population will be lower (that is, the one-tailed test is employed).

The Discharge dimension (objective and subjective questions about preparations for and readiness for discharge) is the only one that focusses on a patient's leaving the group he has been part of. With only seven questions, it is in no way a full exploration of the discussions the patient and therapist may have had about separation from the ward. Issues of therapy termination or of a shift towards referral planning as the therapeutic task are not raised. The questions are meant to test agreement about three issues: the setting of the discharge date; the patient's readiness for discharge; and the degree of support for discharge among other ward staff. At 85.7%, the median agreement score is higher than any on other dimensions; the mean at 68.8% is the second highest. Over all patient-therapist pairs the number of items which could not be scored for agreement is low (8.3% of the total). However, one of the nonattending patients could be scored on only two items. If this patient is omitted from the statistical the dimension is significantly related to outcome at $p \leq .05$.

Lack of agreement about discharge date occurs in two forms in the sample: patients reporting that no discharge date had been set (two of two disagreements on question 0); and patients reporting that they had known the date for a shorter time than the clinician reported (eight of ten disagreements on question 2).

Failure to agree about the patient's readiness for discharge usually means in this sample that the patient is more pessimistic about his readiness than the clinician is (six of seven disagreements on item P3-C3); and that the clinician overestimates the patient's opinion of his own readiness (four of five disagreements on item P3-C4). In this sample, lack of agreement about the clinician's judgement of the patient's readiness occurs when the patient "does not know" his clinician's opinion (three of three cases lacking agreement).

No pattern of disagreement emerges from item P5-C5. In two of five disagreements the patient made the higher estimate of ward staff help with discharge, and in three disagreements the lower estimate.

Other than lack of agreement, no particular configuration on these questions has been noted that describes the nonappearing group, although they tend to be represented by one or two members in the atypical disagreement stance. The practical significance of data on this dimension is mainly that it characterizes the patient member of the disagreeing pair as reporting either no notice of discharge or a shorter notice than the therapist describes; and less readiness for discharge than the therapist either perceives himself, or believe the patient perceives. The patient member of a disagreeing pair seems to feel he is being hurried out of the ward. The significant correlation of scores on this dimension with outcome suggests that a much more thorough exploration of issues involved in a patient's leaving his group (the ward and the therapeutic dyad), might yield practically important insights into aftercare non-appearance. Moreover, the ward is undergoing a crisis of integration (more apparent on the longer-stay wards) when a patient leaves, and still

other effects of this on him may correlate with the degree to which he and his therapist have come to a series of understandings about discharge issues.

In contrast to Discharge, the dimension Mental Hygiene Clinic Contact (objective and subjective questions about matters specifically related to apprising the MHC of this referral and advising the MHC about patient and treatment) has the lowest mean and median agreement scores -- 49.7% and 50.0%, respectively. On Table 25 ranking all questionnaire agreement items by score, 5 of the items of this dimension can be found among the lower one-third, 6 in the middle third, and 2 in the upper third. Nine of the thirteen questions in this dimension had 16 or more agreement scores (that is, were answered by at least 16 patient-therapist pairs); two questions have 12 scores (questions 29 and 30); one question has 7 and one 4 scores (questions 32 and 40). The percentage of scores missing for all reasons including subordination is 21.5%, which is high among the significant dimensions. The three patients who did not appear for after-care were scored for nine, nine, and ten items; the dimension mean number of items scored for any patient is 10.5.

A discussion of this dimension was begun on p. 69 above, where a sketch was given on MHC contact from the patient's perspective. The only statistically significant difference between patient outcome groups observable on the basis of patient responses alone is on question 28. Among patients who did not appear for aftercare, none said his therapist had contacted the MHC, whereas thirteen of sixteen patients who appeared answered that their therapists had done so. The groups are not otherwise distinguishable on the basis of patient answers alone when individual questions or the number of "positive" responses are considered.

In looking at individual items again for agreement scores and patterns of paired responses, the only notable difference between outcome groups is again on item P28-C28. None of the nonappearing patients were in agreement with their therapists about MHC contact. Thirteen of sixteen patients in the other group were in agreement with their clinicians. Although this conformation of results does not aid in predicting what patient will not appear for aftercare (since there are three patients in disagreement who do appear and three who do not), the distribution of data is significant ($p \leq .02$ by Fisher's exact probability test). This means simply that if one were to choose all possible groups of three patient-therapist pairs, fewer than 2 of the groups would unanimously lack agreement, and the nonappearers would be among them. One would not be surprised to find one such significant result by chance, however, when as many items are considered as here.

All of this suggests that the ability of the MHC dimension to discriminate the two populations is not reducible to a series of simpler discriminations by single agreement items or by patient responses alone. The rest of the discussion of this dimension will portray referral work generally with only a brief comment toward the end about a pattern characterizing the responses of the two outcome groups. Therapists' responses and agreement scores will be used to supplement the picture of patient answers given above. It is assumed that the general picture is interesting both for itself and because it is the overall lower rate of patient-therapist agreement that marks nonattenders.

All therapists had either contacted the MHC or planned to do so (questions 28 and 31). Three patients (two of them nonattenders) denied

or did not know of any contact with the Clinic performed or planned by their therapists (one nonattending patient said his therapist planned a contact). There was more variation in estimates of the need for this contact (questions 26 and 27), both among patients (see p. 69) and therapists; twelve therapists thought it important to advise the MHC about the patient (five thought not), and fifteen thought giving treatment advice was important (two did not). Two therapists were neutral on both questions. Of eight disagreements on question 26, six involved patients whose affective allegiance to the therapists' talking with the Clinic was stronger than the therapists' estimate of the importance of this work. There are sixteen scores for question 27; of the nine disagreements, in only four does the patient express the greater enthusiasm. The results are of interest because they suggest not only that patients' affective valuing of the passage of information about them and their treatment disagrees with their therapists' clinical valuing in roughly half the cases, but also that patients and therapists may be out of phase with respect to which part of this work they value most, with more patients being skeptical about the therapist's involvement in treatment planning, and more therapists thinking this contribution to be an important one.

Questions 29 and 30 ask whether patient and therapist think these two kinds of work have been done thoroughly (clinician question) or sufficiently enough so that referral will go well (patient question). Three of nineteen therapists answered both questions on the negative half of the scale; two of these had said the work was important (questions 26 and 27). Four of six patients who answered "no" or "don't know" to one or both of questions 29 and 30 felt positively toward the work. Nine different dyads are involved in these ratings. Where patients and therapists

lacked agreement on these two questions, therapists usually thought the work thoroughly done (nine of ten instances). Patients were more likely to answer "don't know" (seven) than to disagree (two).

One final measure of agreement about the role of the therapist can be described. Question P32 ("Do you think your clinician knows you want him to talk to the outpatient service more?") was asked of patients who were favorable to at least one kind of contact between therapist and MHC (questions 26 and 27) and who answered "no" or "don't know" to questions assessing the actual contact (questions 28, 29, and 30). Ten patients qualified and seven answered the question. Two of the ten therapists answered "yes" to question 32 ("Do you think the patient wants you to have further discussions with the clinic?"). Most (six) did not know. Looked at in this way the item measures the therapist's awareness of a desire (on his patient's part) that he do more referral work. Evidently the awareness is small. Looked at for agreement in the usual sense, item 32 measures whether the patient is ignorant, right or wrong about what the therapist knows of the patient's desire. There were no agreements among the seven scores (four patients responded that their therapists knew, but were wrong; and three said they did not know).

Questions 33, 34, and 35 lie in the area of mutual responsibility for referral work. On question 33 (asking whether patient and therapist have discussed what the therapist might tell the MHC) eight dyads agree (two "yes" and six "no") and eleven disagree (the patient answering "no," the clinician "yes"). One might guess that something about such a discussion brings out a tendency in the patients to deny that it has occurred. This of course cannot be determined through the questionnaire, although

one possible reason for such denial is not supported: clinician answers to question 34 ("As far as you know, do you and the patient have different ideas about what you should say to the clinic?") do not differ between those dyads who agree on question 33 and those who disagree (that is, those where the patient said the discussion had not occurred and the therapist said it had).

The last area to examine has to do with the roles of people other than the therapist in MHC contact, namely the patient and third parties. Patient and therapist agree thirteen of eighteen times about whether the patient has contacted the MHC (four "yes" and 9 "no"), and fourteen of seventeen times about whether the therapist advised such contact before discharge (three "yes" and eleven "no"). Three patients report not receiving advice when the therapists say it was given. Asked whether a third person was available to help the patient with his transition to Clinic, seven therapists of nineteen answered "yes", seven did not know, and five answered "no." Eighteen agreement scores exist for this question, with seven agreements (four "yes" and three "no"). On a series of five questions having to do with MHC contact (question 28 - has the clinician made contact?, question 31 - does he plan to?, question 36 - has the patient made contact?, question 38 - has he been advised to?, question 39 - is there someone else to help?) there are only four instances of agreement involving the patients who did not come to aftercare, and all of these are agreements in the negative.

The MHC dimension has been looked at for evidence about the therapist's role, the patient's role, and the role of others. To the earlier summary of the patients' perceptions, information can be added from therapists' responses and agreement scores. In this sample, patient and

therapist agreed well about an item of fact -- whether the therapist had contacted the Clinic. There was fairly frequent disagreement though about the importance of this contact, with an added patient-therapist discrepancy in the particular part of the therapist's work being most highly valued. Therapists rated their actual performance in contacting the Clinic high. Patients were less sure, and it is doubtful that in their answers they were going on much evidence, since very few patients said they discussed at all with their therapists what might be said to the MHC. Another question aimed at assessing shared information having to do with the therapists' role, question 32, suggested that therapists had little awareness of the patients' wishes for them to speak further to the MHC. Therapists who do not think their patients have contacted the MHC or who have not advised them to are, like the patients who report no contact and no such advice, in the majority. Agreement on these questions runs high. The majority of therapists as well as patients thought no third person would help with referral or transfer, although in their pooled knowledge, such a person was thought available in most cases. Evidently the possible contribution of third parties is little discussed. And finally, it seems to be the frequency with which patients who do not come to aftercare give various responses with which their therapists do not agree (rather than the responses themselves or those of their therapists) that distinguishes this group from the aftercare attenders.

The two remaining dimensions that are significantly correlated with outcome, Principles and Clinician's Acts and Plans, are made up of items from several other dimensions. Principles shares items with the Discharge,

MHC Contact and Significant Others dimensions (and as will be explained below, this dimension was later assigned several more items, three of them from Outpatient Treatment). All of the dimensions that contribute items to Principles and to Clinician's Acts and Plans have already been treated in this chapter except Outpatient Treatment. To reexamine what is shared with these contributing dimensions would add little new information, since those items seem most informative in their primary contexts. For that reason, and because the dimension Outpatient Treatment itself approaches a significant correlation with outcome ($.10 > p > .05$) it will be the last dimension to be fully discussed.

Outpatient Treatment (consisting of objective and subjective questions having to do with general aftercare concerns) has mean and median agreement ratio scores of 65.8% and 72%, respectively. It is one of three similarly-scored dimensions which together with Discharge and Information have means and medians in the upper part of the scoring range. Nineteen items comprise the dimension; patients were scored for a mean of 15 items and the nonappearing group was scored for 14, 12, and 10 items. Twenty-three per cent of answers are missing overall for all reasons including subordination. Twelve items are scored for 17 or more patients; one item for 15 and two for 14 patients; and the others for 9 patients (the second item P13-C10), 7 patients (the second item P10-C13), 5 patients (numbers 7 and the second item 19), and 1 patient (item 23).

Examination of patient responses and of agreement scores, item by item, reveals a single item which gives a statistically significant differentiation of outcome groups ($p < .01$, by Fisher's exact test). In answer to question 18 (asking whether the clinician has prescribed

medication for outpatient use), two nonappearing patients were the only ones to answer "no" and "don't know" while their clinician answered "yes." The same reservations about this kind of analysis which were mentioned in discussing the MHC dimension apply here as well, and no attempt will be made in what follows to specify the responses of the two outcome groups separately for each measure. It is possible of course that with a larger sample, other details of the distribution of single answers or agreement scores would emerge as significant.

As derived from the clinician's responses, the general picture of the patients' treatment needs and options matches what has been based on the patients' self-reports. Not surprisingly the clinicians find these patients to have problems appropriate to the Clinic (alcohol abuse is mentioned for two patients, one of them a nonattender, but never as the only problem). Sixteen therapists report discharging their patients on medication but only two patients are recommended for medication follow-up alone (no nonattenders among them). Only one therapist says his patient will seek psychiatric help elsewhere; fifteen say "no" and three "don't know." Sixteen expect their patient to begin treatment at the MHC; three (one speaking of a nonattender) say they don't know.

Patients' estimates of the helpfulness of aftercare matched therapists' estimates of the need for it in twelve cases; five of six discrepancies involved patients' rating its helpfulness below the corresponding therapist rating (question 8). Most of the patients (eleven of seventeen) and most of the therapists (eleven of nineteen) believed themselves to be in agreement with the other member of the pair about the kind of need for, or use of, outpatient treatment (question 12). This sense of agreement

was mutual in seven of seventeen pairs. The lack of parallelism in the two versions of question 9 (asking the patient what he wanted from treatment, and asking the clinician for the main problem requiring treatment) removes an objective check on each person's answer to question 12. Two other items can be checked, however, for correlation with the patients' answers to this question. Neither is strongly correlated. Patients' reports on question 12 do not correlate with patient-therapist agreement score on either the valuation of aftercare (item P8-C8) or the type of aftercare preferred (item P10-C10). (Patient reports on question 12 are dichotomized to "yes" or "no or don't know" for this comparison.) If a more perfect version of item P9-C9 were also to prove uncorrelated with P12, and the same were found for similar pairs of patient responses and item agreement in other areas of referral work, the result would be of interest. It would suggest that disagreement on a matter like question 9 is not associated with any sense of discord with the therapist which the patient felt or was willing to express. It would then be difficult to argue that it was by means of such an association that patients who frequently did not agree with their therapists also tended not to appear for aftercare. The nonappearing group in this sample does not help clarify this. One patient replied positively to P12, agreed with his therapist about one of two modes of aftercare, and disagreed about the evaluation of aftercare. The other patient who responded to P12 answered "don't know;" he and his therapist agreed on both item P8-C8 and P10-C10.

Questions 10 and 13 ask what kinds of therapy would be best for the patient (10) and what kinds the other member of the dyad wants or advises (13). Two answers may be recorded for each question. When independent opinions are compared (item 10), twelve pairs agree about at

least one choice of therapy (seven of these disagree and one agrees about a second choice, and seven do not agree at all). One might expect that since a clinical recommendation is probably being made by the therapist, his opinion should be accurately known by the patient more often than the patients' preferences would be known to the therapist. Patients and clinicians mention twenty-five treatment recommendations in P13 and C10 altogether. They correspond fifteen times. In P10 and C13, twenty-five treatment preferences are mentioned, and they correspond eleven times. This result favoring knowledge of the therapists' suggestions over the patients' preferences does not reach statistical significance however.

Although the numbers are all very small here, there is a suggestion on looking at item 10 that the therapist recommendations least likely to be repeated by the patient are group therapy (lacking four agreements out of five recommendations), and family therapy (lacking four agreements out of four recommendations). A therapist's recommendation of individual psychotherapy, on the other hand, is matched by the patient seven times out of eight. These peculiarities perhaps explain the good agreement scores of the three nonattenders on this item. Their three out of four agreements are for individual work and the disagreement is for group.

The last group of items to be considered here are the four concerned with outpatient medication (questions 18, 19, 20, and 21). Question 18 has been discussed above, as the single item permitting significant differentiation of outcome groups. On twenty mentions of medication by therapists, patients concurred thirteen times. There was one disagreement about medication and in six cases patients failed to mention a drug listed

by their therapist. All fourteen patients who said they were being discharged on medication also said they would take it and come to the MHC for it. Their therapists said the same in eleven instances, and in three did not know.

In summary there appears to be an overall simplicity in patient and therapist descriptions of certain general characteristics of this sample as potential consumers of aftercare services. Looking in closer detail, one finds good agreement about medication issues (except for a tendency of patients on two medications to forget one of them). An excursion into the patients' sense of their therapists' agreeing with them about the use of outpatient therapy revealed no correlation of this measure of perceived understanding with the achievement of a shared view of two other clinical judgements (the need for therapy, and preferred mode of therapy). Agreement on what kind of therapy would be best was not good (45% overall), and therapists were no better (44% accuracy) at describing the patient's expressed therapy preferences. Although patients named their therapists' recommendations correctly at a higher rate (60%) the difference was nonsignificant. It does suggest however that patients are able to report personal preferences in therapy that differ from what they believed their therapists' recommendations to be.

In its original composition the dimension Clinician's Acts and Plans (questions about what the therapist has done or plans to do in arranging aftercare) excluded acts of the clinician that had to do with advice given by the therapist to the patient. These items instead made up most of the dimension, Clinician's Wishes of Patient. Although this dimension is not significantly related to outcome, the Acts and Plans dimension achieves significance in both its forms ($p \leq .025$ in the original form;

$p \leq .01$ augmented). The augmented form has the advantage of assembling all questions about the clinician's acts into a single dimension. As such it consists of thirteen rather than eight items. Eight items are scored for 17 or more pairs, two for 15 pairs, one for 13 (item P55-C53), one for 12 (item 49), and one for 6 (item 52). The mean number of questions answered is 10.6 (one patient scored for only 5 items is not included in these statistics or in the significance test ranking, although his inclusion in the ranking would slightly enhance the p value). Non-attending patients were scored for eight items each. The proportion of scores missing for all reasons is 14%.

The dimension assembles items from Outpatient Treatment, MHC contact, and Significant Other dimensions that have to do with what the therapist has done or plans to do. Although only one of these dimensions of origin is significant at $p < .05$, the dimension so assembled is highly significant.

A largely parallel dimension, Patient's Acts and Plans, fails to achieve a significant correlation with outcome. Mean and median scores on the two dimensions also differ (Clinician's mean = 61.2, median = 64.5; Patient's mean = 65.5, median = 71). These differences in mean and median are much more marked for the original Clinician's dimension that excludes the therapist's acts of advising the patient (mean = 52.6%, median = 53.5%). One might speculate that in current custom it is harder for the patient to know what referral work his therapist has done than vice versa, but that this is the more important knowledge. An alternative interpretation of these dimensional results, however, will be discussed in the next section. Details of agreement within the dimension will not be

repeated here from the earlier discussions.

The Principles dimension (questions asking patient and therapist for assessments of the patient's current situation and of his needs) is also significant in its original form ($p < .05$) and after augmentation ($p < .025$) by four items which should be included for completeness, but were initially overlooked. Over the whole dimension, items are shared with two significant dimensions (MHC Contact and Discharge) and a non-significant and a borderline dimension (Significant Others and Outpatient Treatment), all of which have been discussed. The augmented dimension consists of sixteen items. Ten are scored for 16 or more pairs; one for 15 (question 43); two for 14 (44 and 45); two for nine (50, and P13-C10 the second answer); and one for 7 (P10-C13 second answer). The mean number of items scored per pair is 13.7. Nonattenders were scored for 13, 9, and 14 items. 14.4% of possible scores are missing. It is a fairly low-scoring dimension (mean score = 53.3%, median = 57%).

This dimension has a less clear-cut definition than the others. In conception it is meant to include all items which on the questionnaire are cast in the form of questions about clinical judgement (Clinician questionnaire) or preferences (Patient questionnaire). Two different types of items are included. One type (for example, P10-C10) compares the separate opinions of patient and therapist (about mode of outpatient therapy, in this case). The other type (for example, P10-C13) attempts to judge one person's knowledge of the preference or judgement of another (the patient's knowledge of what treatment his therapist will recommend). Thus separate valuing of various situations are compared and awareness of others' valuing is tested. Again, the details of earlier discussions will not be repeated.

VI. Discussion

Unlike most of the research that has been done in the area of after-care utilization, this project has not had as its goal the identification of a "predictor" of which patients will fail to come to outpatient treatment. As noted in Chapter One of this thesis, few facts about a patient have been found to predict appearance; and there is the additional problem of knowing what to do with a predicting factor like gender, or presence of schizophrenia, or race. Too many people possess the characteristic. And knowing that white males, for example, are "at risk" is not yet to know by what maneuver the risk could be reduced. This project has used ideas from the theory of groups, rather than from concerns appropriate to the allocation of delivery of mental health services. The model of referral work sketched in Chapter Two locates the concerns of this project in that aspect of the functioning of a psychiatric inpatient service. In keeping with this, most of the effort of the present chapter has been to describe and speculate about many specific areas of referral work. A lesser part of the effort has been to correlate the "completeness" of the work with one outcome measure -- appearance for aftercare -- not to learn how to predict appearance but to place a value from one measureable source on the gradations of "completeness" in the inpatient work.

The detailed description of referral work given in the pages above may be biased in several ways. First, as has been noted, a number of patients who qualified for the study were not interviewed, so the work of these patient-therapist pairs cannot contribute to the picture given. Since some of these patients were discharged suddenly or left suddenly on their own and were discharged in absentis, and since all of them took

up lives on the outside that made them hard to contact, there is reason to think their referral work might have been different from that of the actual sample. No comparison of demographic factors of the sample and the missed populations would change this suspicion. Second, the inclusion of patients from the admission and brief treatment unit (from which two of the nonappearing patients came) in a single analysis with those from intermediate-stay wards may bias the agreement results toward the lower end of the scale. The four attending patients from this ward divide evenly, two above and two below the mean for the agreement ratio of attending patients (63.7% agreement) and their mean score is close (59.5% agreement). However the overall mean scores are distinctly different, with the short-stay patients averaging 53.8% agreement and the total sample averaging 60% agreement. While it is not possible to separate short- and intermediate-stay populations (U test nonsignificant), the level and perhaps the kinds of agreement are affected by this difference in the inpatient units.

Third, over the seven weeks of data collection several therapists completed multiple questionnaires, so that a sort of training effect may gradually have altered their actual practice with patients. The clinician questionnaires might have been seen by some as a checklist of what should occur in referral work. Any attempt by the clinicians to bring their practice more into line with this prescriptive aspect of the questionnaire might alter both their report of the work they did, and the patients' report. Although the discharges of each therapist were coded in sequence so that a training effect could be looked for, the small total N of this study would so seriously compromise the effort that the analysis was not

made. In a larger study, techniques of trend analysis might offer some insight. It is hard to imagine how else to control for such an effect, since the data clearly cannot be gathered "blind."

If the training effect actually improved referral work (in the sense of this study) then a belief in the theory underlying the study would lead one to suspect that the project had increased the number of patients who attended Clinic. The effect of an event like this is not simply on appearance rates because if the training effect applied uniformly, then as time went by the improving level of work would gradually take up the variation in attendance caused by variation in the tested quality of work and cause attendance to be more powerfully determined by other factors. This would be detected as a decreasing ability of agreement scores to account for appearance and nonappearance.

The fourth source of bias in the picture of referral work may be in the selection of questions for the questionnaires. Clearly the universe of possible questions has not been exhausted. There is more emphasis on the role of the clinician than on roles of the patient or of third parties, such as other staff. If a great deal of discussion between patient and therapist revolved around what these people could do, areas of possible agreement would not be adequately represented in what has been written. New questions might also explore the therapist's role with greater depth and specificity. Although the general level of agreement about what the therapist has done or might do does not seem so high that more questions should be added to adjust the power of the questionnaires to discriminate individual pairs, increased specificity would be expected to cause some shifts in the agreement picture as well as in the overall

descriptions of patients' and clinicians' experiences of the work.

The last source of bias that will be discussed is observer bias. The researcher was previously inexperienced in administering questionnaires and was aware of certain changes in his manner during the period of data collection which were perhaps partly responsible for a general increase in the number of questions patients found themselves able to answer. Standard research problems of inter-observer reliability in administering questionnaires have not been attended to in this project.

One should also question the reliability of both the patients' and the therapists' answers. This project does not include a design for checking the internal consistency of answers, testing for temporal variation in answers that could not be explained by further contact between patient and therapist or further work done by either, or for characterizing individual styles of response to questionnaires and interview situations. Error arising from any of these factors might affect both agreement scores and the general description of referral work given in this paper. Social desirability of certain answers, and the acquiescent response set are two well-known factors of individual style that can cause error (see discussion in a text like Selltiz, Wrightsman, and Cook, 1970). Idiosyncratic or delusional interpretations of the interview by patients, as well as concerns about evaluation on the clinicians' part, are other sources of error that may have affected study results. A patient given to unreliable answers (a sociopathic patient, for example) might also have low interest in continuing treatment, particularly if it were clear that no financial benefits could be obtained from it. On the other hand, if money were tied to attending treatment, such patients

might come despite their unreliable answers and low agreement scores.

Several additional kinds of explanations might be made for why patients did not appear for aftercare, other than incomplete referral work. This paper does not mean to claim that the quality of referral work acts alone. Patients who did not appear may all have been helped elsewhere, or have been the only patients in the sample whose willingness to come encountered practical barriers which defeated them, such as the opposition of relatives, lack of transportation, jobs with unfavorable hours, and so on. Such explanations need not exclude the referral factor, either, since part of discharge and referral work is to foresee such tendencies in the patient or his situation and approach them as problems to be worked out before the patient left the hospital. Work like this is done all the time, of course, on inpatient wards. The questionnaires contain a final section of twelve questions meant to explore what work had been done to circumvent such obstacles before they prevented attendance. This section has not been discussed because patients rarely reported any obstacle, and when they did their therapists reported either none or a different one. It was also thought that several of these practical barriers would be detected by earlier questions, such as those in the screening group, and by questions about the attitudes of relatives and friends toward aftercare. As has been noted already, these single items do not separate attenders from nonattenders, nor do the patients' screening questions. The therapists' screening questions achieve a marginally significant separation, largely on the basis of the responses of one therapist.

One final factor which can be discussed in the context of outcome

is the prognostic one. Perhaps patients who do not reappear are those who do not need to, because the hospital contact they have had has been sufficient, at least for the time being. Clinicians in training might not be skilled at recognizing this, and may therefore have recommended and valued aftercare for such patients as part of a cautious discharge plan. Patients might have been swayed also by the persuasiveness of a treatment environment, but have recognized their recovery once they were home. The study does not control for such a complex situation.

For this research to show that the correlations it has obtained with aftercare do support the value of more complete referral work, control must be demonstrated over a large number of competing explanations for why low agreement scores and unfavorable outcome might go together. Attempts have been made to consider some of these explanations in the design of the research. This section will take up the discussion of these, and of other alternative explanations not given a place in the research design. There are a large number of plausible alternative understandings. Some were briefly mentioned in Chapter Two and will be discussed here more fully. A lack of interest in outpatient treatment on the patient's part is perhaps the most obvious factor of this kind. It could come about for many reasons. The patient may want to think himself through with treatment. He might think treatment has done all it can for him, or that it has done nothing and can do nothing. He might be frightened by it or feel damaged by it. In any case, having decided he would not return, such a patient might pay little attention to matters of opinion and fact in the referral work. He might be outwardly compliant, and express compliance in his questionnaire, so that his answers to questions

like 8 and 14 would not reveal his decision. A low agreement score would result from the patient's form of deviance -- going along with the work passively and inattentively when the social norm asks for motivated interest. Or if he had a very unfavorable experience of treatment, or a stressful relation with his clinician, a patient might deny that anyone had done anything to help him either in treatment or in referral. Similar factors of course could alter the clinician's response. A negativistic deviance where the norm of referral work asks for respect for the values and efforts of others would lower agreement rates, especially on dimensions like Clinician's Acts and Plans, and the corresponding patient dimension. In this sample there is evidence of such an effect acting within the Clinician's Acts and Plans dimension. On Table 9 the patient responses on the dimension are ranked according to the proportion of answers saying that the therapist planned or performed an element of referral work. The three nonappearing patients fall at the low end of the rank and are discriminated from the attenders at $p < .01$ (U test). In each of nine disagreements involving the three patient-therapist pairs, the therapist reported his acts and plans positively and the patient negatively. However even if this is to be interpreted as negativism on the part of the patient, the situation is not simple. A similar ranking of therapist answers (claiming or not claiming that work was done or planned) places two of the therapists of these patients at the low end of the ranking and the third close enough to the low end so that of all possible triads of therapists, only 2% report doing or planning to do as little.

A dimension of questions constructed at the same time as the agreement dimensions gives another view of the patient's opinion of his

TABLE 9

UNILATERAL AFFIRMATIVE RESPONSES ABOUT CLINICIAN'S ACTS AND PLANS

RANKING OF PATIENT RESPONSES:
% AFFIRMATIVE

0
22
29
30
 33
 33
 36
 36
 36
 38
 45
 45
 45
 50
 64
 64
 75
 78
 78

RANKING OF CLINICIAN RESPONSES:
AFFIRMATIVE/TOTAL

4/11
4/10
5/11
 5/11
 6/11
 6/11
 7/11
 7/11
7/11
7/11
 7/11
 8/11
 8/11
 8/11
 8/11
 8/11
 8/11
 8/11

U test with intervals of .10
running 0-.09, .10-.19 etc.
gives $U = 0$, or $p < .01$.

Nonappearing patients' scores
are underlined.

Of 19!/16!3! separate and distinct
groups of three therapist scores,
only the following triplets have
scores as low as or lower than
the triplet of scores for therapists
of nonappearing patients:

4,4,5 of which there are 2
 4,4,6 of which there are 2
 4,4,7 of which there are 5
 4,5,5 of which there are 2
 4,5,6 of which there are 8

total 19

% of triplets with equal or
lower affirmative scores is then

$$100 \times 19//19!/16!3! = 2\%$$

therapist's referral work, which may be compared with what has just been described. Unlike the agreement dimensions, the "Good Therapist" dimension scores patient responses without reference to the clinician's questionnaire. The dimension measures the extent to which the patient reports that his therapist's opinions agree with his own; his therapist's acts and plans agree with what the patient thinks important for the therapist to do; and that his therapist's knowledge of the patient includes knowing what the patient would like him to do. A similar dimension was constructed from clinician questions. The "Good Patient" dimension consists of questions and combinations of questions attempting to measure to what extent the therapist reports that his patient agrees with him and will act as he advises. (The composition of these dimensions and the scoring rules are given in the Appendix, pp.131-132 .)

These dimensions were assembled in order to see whether concepts so defined might separate outcome groups without reference to agreement between patient and therapist. A high score suggests that the subject sees the other member of the dyad as having preferences like the subject's and doing or planning to do what the subject would wish him to. A degree of fusion may be implied. The score for a patient or therapist on these dimensions is the ratio of items answered favorably to the other member of the pair, to the total number of questions answered favorably, unfavorably, or with ignorance of what the other member believes, knows, or will do. Rankings of the subjects on these two scales are presented on Tables 23 and 24, ^{pp 133-134,} along with the results of applying the U test. Neither dimension separates the populations significantly. On the Good Therapist dimension one nonappearing patient has next to the lowest score (25% favorable

response) but another is at the median (67% favorable responses) and a third is just above the median (71%). Evidently scores of this notion of "the good therapist" do not generally situate nonappearers among the rest of the patients as do positive answers to the patient questions of the dimension, Clinician's Acts and Plans. Perhaps negativism toward a therapist's referral accomplishments (particularly when the therapist has done relatively little work on contacting the Clinic) is more sensitively linked to the patient's intention to attend Clinic than is a ranking (in the image of the patient's wish) of the overall work done by the clinician.

Two other possible causes of both low agreement scores and discontinuation of treatment are the degree and kind of the patient's mental turmoil at discharge, and the importance of the termination issues left unresolved at discharge. The present study does not have a strategy for detecting either factor or taking them into account. Mental turmoil might prevent a patient from agreeing for long with any discharge plan, or any estimate of his own condition and needs. One would expect discrepancies between the pictures of referral planning given by therapist and patient in this situation. After discharge, the patient might ambivalently reject his referral plan. The possible intrusion of termination issues into the referral planning process has been mentioned in Chapter Two. In the ensuing conflict and stress caused by working on reality-oriented issues of referral planning, both patient and therapist might misrepresent the work or express bafflement about it (leading to a high proportion of "don't know" responses). It has been suggested (Pumpian-Mindlin, 1958) that for patients made very anxious by separations, a

flight from treatment at the time of transfer becomes more likely as a result of such a coloring of referral work by termination issues.

A patient's lack of interest in aftercare and inner turmoil at discharge, and the patient and therapist's unresolved termination issues which have been presented as alternative explanations for the agreement-outcome correlation, all intersect extensively with the therapeutic tasks of a psychiatric hospitalization. Defining the implications of the correlation means first defining what referral work undertakes to do in relation to what the ward has undertaken. This has not been done in the present study, but several areas of referral work have been explored in which the connection with aftercare appearance suggests that an interesting picture might be defined. These areas have been described in this paper as the agreement dimensions having to do with discharge, outpatient treatment, contact with the Mental Hygiene Center, evaluative principles, and the referral acts and plans of the clinician. In all of these dimensions the patterning of shared knowledge has been surveyed with attention to regions of high and low expectation and performance by patient or therapist, and of high and low agreement between them. These regions include certain basic assessments of the discharge and referral situation including the perception of appropriate mutual roles and the nature of referral goals; awareness of one another's assessments and goals; and awareness and approval of one another's acts and plans in referral work, particularly with reference to contact with the Mental Hygiene Clinic. The perspective of Chapter Two has it that work in all these areas demands certain reevaluation of the therapeutic task with a patient approaching discharge, and that these reevaluations might be particularly troublesome but also might offer opportunities for patient and therapist vis a vis

one another. The correlation of agreement with aftercare appearance has been superimposed on these discussions in order to suggest that the completeness of referral work within its context of difficulty may have important effects on future patient care.

CHAPTER FIVE: SUGGESTIONS FOR FUTURE WORK

The preceding chapter has discussed various issues of experimental design and control, including problems of reliability and validity in this project. In order to cope with these problems and to test hypotheses suggested by the present work, a new research design would be needed. One possibility will be briefly sketched. Its general hypothesis is that patients on intermediate-stay wards who work with their therapists on referral issues will have better subsequent treatment histories than patients who do not work with their therapists on these matters.

This study would require an experimental design allocating patients to two groups for referral planning. The experimental group would begin discussions with their individual therapists, and the second group would be told by their therapists that they should ask the Clinic directly for any information they might want. Therapists of experimental group patients may or may not be instructed about referral work; in any case one would want some instrument by which one could survey the work that was done in these dyads. If the instrument were a set of questionnaires again, they should be newly designed with two principles in mind: to cover more thoroughly the areas of work found correlated with outcome in the present study; and to coincide more closely with ideas of completeness of group work such as those presented in Chapter Two of this paper. The goal should be to write a questionnaire which on analysis would yield measures related to the strains of new task definitions and to the amount and kind of work it was possible to do before discharge.

In view of the narrowness of the outcome measure used in this project,

additional measures should be sought. They should not be simply data on rehospitization or length of outpatient attendance. They may also seek to reflect effects of referral work on the inpatient wards of origin.

Attention must be paid in design also to standard techniques of testing instruments for reliability and validity. Multiple observers, and discriminating and parallel instruments such as those measuring social desirability, the acquiescent response set, degree of psychological instability at discharge, and so on should be used. A great deal of planning must go into the allocation of patients to one or another group, and into the schemes of matching or stratifying patients and therapists, in order that the groups be comparable.

The outcome of such a project would then be, first, information about whether the individual therapist-patient relationship is a favorable or unfavorable environment for referral work; and second, a description of change and accomplishments within that relationship that may be related to its effectiveness.

APPENDIX

PATIENT QUESTIONNAIRE

0. Was a discharge date set for you? Yes/No/don't know
1. What is your discharge date? ____ / ____ / ____
2. When did you hear of it? _____
3. Do you think you will be ready for discharge then?
 ready _____ not ready
4. As far as you know, does your clinician think you will be ready for discharge then? Yes/No/ don't know
5. Has the staff on your ward helped or made it harder for you to be ready for discharge on your discharge date?
 very helpful _____ made harder
6. Have you ever been in treatment at the outpatient clinic here before?
 Y / N / don't know
7. How long ago was this? _____
8. Do you think outpatient treatment of some kind will be helpful to you after discharge? very helpful _____ not helpful at all
9. What would you like to get from outpatient therapy?

10. What kind of outpatient treatment do you think would be best?

11. Has your present clinician advised you to have outpatient treatment here? Y / N / don't know
12. Do you think your present clinician sees what you need to get from outpatient therapy the same way you do? Y / N / don't know
13. What kind of treatment does he/she advise? _____
14. Do you plan to come to this hospital for outpatient treatment?
 Y / N / don't know
15. Would you be more likely to come if you and your clinician agreed about what your outpatient therapy should be about?
 much more likely _____ no difference
16. Would you be more likely to come if you and your clinician agreed about what kind of therapy you should have?
 much more likely _____ no difference

17. Will you have transportation to get here for outpatient therapy?
Y / N / don't know
18. Does your clinician advise you to take any psychiatric medications as an outpatient?
Y / N / don't know
19. What medications? _____
20. Do you plan to keep taking these medications as an outpatient?
Y / N / don't know
21. Do you plan to see a doctor at this hospital for these medications after your discharge?
Y / N / don't know
22. Do you plan to look for psychiatric or psychological treatment from any place other than this hospital following your discharge? Y / N
23. Where? _____
24. Do you expect to keep seeing your present clinician after your discharge? Y / N / don't know
25. Do you expect to keep in touch with any other staff from your ward after discharge? Y / N / don't know

Before a patient begins outpatient treatment his ward clinician often tells the outpatient service something about the patient and his needs. The clinician may also give advice about the kind of therapy the patient will need after discharge.

26. Would you feel better or worse about beginning outpatient treatment if you knew your present clinician had given the clinic some information about you and the reasons for your treatment?
much better _____ much worse
27. Would you feel better or worse about beginning outpatient treatment if you knew that your clinician had given advice about your outpatient treatment?
much better _____ much worse
28. As far as you know has your present clinician contacted the outpatient clinic about you? Y / N / don't know
29. Do you think your clinician has given the clinic enough information to help your referral go well? Y / N / don't know
30. As far as you know, has your present clinician helped the outpatient clinic plan your outpatient treatment? Y / N / don't know
31. Do you think your clinician does plan to talk more with the outpatient service about your referral and treatment there? Y / N / don't know
32. Do you think your clinician knows you (want / don't want) him to talk to the outpatient service more? Y / N / don't know

33. Have you and your clinician talked over what he might tell the outpatient clinic about you? Y / N
34. Do you and your clinician agree on what he should say? Y / N / don't know
35. In what ways might your ideas be different if at all?
-
36. Have you talked to anyone from the outpatient clinic about getting treatment there? Y / N
37. Do you plan to talk to anyone from the clinic before you leave the hospital? Y / N / unsure
38. Has your clinician said you should talk with the outpatient clinic before you leave the hospital? Y / N
39. Do you know of any person beside your therapist who might help you with your transfer to the outpatient clinic? Y / N
40. Who? _____
41. Some patients have family or friends who are important to them and whom they see a lot after they are discharged. Are there people like this for you whom you will be seeing a lot after your discharge? Y / N / don't know
42. Who are they? _____
43. How do you think these people feel about your going to outpatient treatment? strongly in favor _____ strongly opposed
44. Will you come to outpatient treatment even if these people think it is not important for you to come? Y / N / don't know
45. Will you come to treatment even if these people think you should not come? Y / N / don't know
46. Have you spoken with any of these people about your outpatient treatment? Y / N /
47. What people have you spoken to? _____
48. Do you plan to talk more to these people about outpatient therapy before you are discharged? Y / N
49. Has your present clinician said you should talk some more to your family or friends about your outpatient treatment before you leave the hospital? Y / N
50. Do you think your family or friends would listen to your clinician if he told them that outpatient treatment is a good thing for you? Y / N / don't know

51. Has your clinician talked with your family or friends about your out-patient treatment? Y / N / don't know
52. What people has he/she talked with? _____
53. Do you hope your clinician talks (some more) to them about your future treatment? very important _____ not important
54. What people should he/she talk to? _____
55. Do you think your clinician does plan to talk (more) to your family or friends about these matters? Y / N / don't know
56. Do you think your clinician knows you want him/her to talk (more) with these people? Y / N / don't know
57. As far as you know, have any other staff spoken with your family or friends about your outpatient treatment? Y / N / don't know
58. Have you thought of anything else that might make it hard for you to get the outpatient treatment you want? Y/N/don't know
59. What might this be? _____
60. Do you feel you need help from your present clinician with this problem? Y / N / don't know
61. Do you think your present clinician knows about these problems? Y / N / don't know
62. Do you think your clinician will help you with these concerns? Y / N / don't know
63. Why might he/she not help? _____
64. Do you think your clinician feels he can't help? Y / N / don't know
65. Do you think your clinician feels that you can handle this yourself? Y / N / don't know
66. Does your clinician know you want help with these problems? Y / N / don't know
67. Has your clinician helped you already with these matters? helped a lot _____ no help
68. Do you know of anyone else who can help you with these concerns? Y / N
69. Who might this be? _____

CLINICIAN QUESTIONNAIRE

0. Was a discharge date set for this patient? Yes / No
1. The date is ____ / ____ / ____
2. About how long before discharge was the patient told the date?
_____.
3. Do you think the patient will be ready for discharge then?
ready ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ not ready
4. Does the patient think he will be ready for discharge then?
Y / N / patient not sure / don't know
5. Do you think that discharge at this time is congruent with the expectations and efforts of ward staff for this patient?
congruent with expectation ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ counter to expectation and effort
6. Has the patient been in treatment before at the outpatient clinic here. Y / N / don't know
7. If so, how long ago was he last in treatment? _____.
8. Do you think the patient will need outpatient treatment?
necessary ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ not necessary
9. What is the main problem for which this patient will need treatment?
_____.
10. What kind of therapy available in the Clinic do you think would be best?
_____.
11. Are you advising the patient to go into outpatient treatment at the Clinic? Y / N
12. Do you think the patient sees the use of outpatient treatment for him in generally the way you describe it in question 9? Y / N / don't know
13. What kind of outpatient therapy does the patient want?
_____.
14. Do you think the patient will come back to begin outpatient treatment? Y / N / don't know
17. As far as you know, will the patient have transportation to the WHVAH for treatment? Y / N / don't know
18. Are you advising the patient to take psychiatric medications after discharge? Y / N
19. What medications? _____

20. Do you think he will take these medications? Y / N / don't know
21. Do you think he will come to the WHVAH for supervision and continuation of medication? Y/ N / don't know
22. As far as you know, does the patient plan to seek psychiatric or psychological treatment from any place other than this hospital after discharge? Y / N / don't know
23. If so, from where? _____
24. Do you expect to continue meeting with this patient after his discharge?
Y / N
25. Do you expect him to keep in touch with other ward staff after discharge? Y / N / don't know
26. How important for the success of this particular referral is it that you advise the clinic about this patient and his problems?
very important _____ unimportant
27. How important is it in this particular case that you advise the clinic about forms of outpatient treatment for this patient?
very important _____ unimportant
28. Have you contacted the Clinic about this referral as yet? Y / N
29. If so, how thoroughly have you been able to cover the information important to referral? very thoroughly _____ scarcely at all
30. How thoroughly have you been able to cover your ideas about the form of treatment with the Clinic?
very thoroughly _____ scarcely at all
31. Do you think you will discuss this referral with the Clinic further?
Y / N / don't know
32. Do you think the patient wants you to have further discussion with the Clinic? Y / N / don't know
33. Have you and the patient discussed what you might tell the clinic?
Y / N
34. As far as you know, do you and the patient have different ideas about what you should say to the clinic? Y / N / don't know
35. If so, in what ways do they differ? _____
36. Has the patient talked to anyone from the outpatient clinic about treatment there? Y/ N / don't know
37. Do you think the patient will speak to the Clinic before leaving the hospital? Y/ N / don't know
38. Have you suggested to the patient that he speak to someone in the Clinic before leaving the hospital? Y / N

39. Is there anyone beside you who can help this patient with his referral?
Y / N / don't know
40. If so, who? _____
41. Does this patient have significant others whom he will be seeing frequently after discharge? Y / N / don't know
42. If so who are they (relation to patient)? _____
43. How do you think those most important to the patient feel about the patient's going to outpatient treatment?
strongly in favor _____ strongly against
(If two important people have different feelings, please mark both.)
44. Do you think the patient will attend treatment even if these people think it is unimportant? Y / N / don't know
45. Do you think the patient will aggend treatment even if these people think he should not? Y / N / don't know
46. Has the patient discussed outpatient treatment with any of these people? Y / N / don't know
47. If so, with whom? _____
48. Does the patient plan to speak to any of them (more than he has already) about outpatient treatment, prior to discharge? Y / N / don't know
49. Have you advised the patient to talk more with significant others about outpatient treatment? Y / N
50. Do you think your speaking to significant others has made or could make them more favorable to the patient's clinic treatment?
Y / N / don't know
51. Have you spoken to significant others about clinic treatment? Y / N
52. If so, to whom? _____
53. Do you plan more talks with them about clinic treatment? Y / N
54. If so, with whom? _____
55. Does your patient want you to talk more to these people about clinic treatment? Y / N / don't know
56. Do you think your patient knows your plans in this regard?
Y / N / don't know
57. As far as you know, have any other staff spoken with significant others about clinic treatment for this patient? Y / N / don't know

58. Are you aware of anything beside what has been covered above that threatens to make it hard for this patient to get appropriate outpatient treatment? Y / N

59. If so, what might this be? _____

60. Do you expect to be able to help resolve this difficulty?
Y / N / don't know

61. Do you think the patient knows about this difficulty? Y / N / don't know

62. Has the patient expected you to help? Y / N / don't know

63. Do you feel the patient can handle the matter himself? Y / N / don't know

64. Do you feel you are not in a position to help? Y / N / don't know

65. If you do not expect to help, are there other reasons for this?

66. How well has the patient dealt with this threat to outpatient therapy?
very well _____ very poorly

67. Have you already been able to help with this difficulty? Y / N

68. Do you know of anyone beside you who can help the patient with this difficulty? Y / N

69. If so, who? _____

Mann-Whitney U Test:
$$U = n_1 n_2 + \frac{n_2 (n_2 + 1)}{2} - N_2$$

where n_1 = number in first subgroup (3 nonappearers)

n_2 = number in second subgroup (16 appearers)

N_2 = the sum of the rank numbers of all scores belonging to the second subgroup.

Thus in this work

$$n_1 = 3$$

$$n_2 = 16$$

and

$$U = 48 + 136 - N_2,$$

where N_2 varies with each dimensional ranking of scores.

TABLE 10

DIMENSION: INFORMATION

ITEMS	PATIENT	RANKED PATIENT-THERAPIST AGREEMENT SCORES	RANK INTERVALS
PO-CO	2	38 %	
P1-C1	8	40	
P2-C2	5	43	
P6-C6	<u>14</u>	43	
P7-C7	13	50	
P17-C17	4	63	Nonsignificant by U test.
P39-C39	6	67	
P40-C40	<u>7</u>	67	
P41-C41	12	70	
P42-C42	<u>10</u>	71	
P57-C57	11	78	
	16	78	
	19	80	
	15	89	
	1	90	
	18	90	
	3	100	
	17	100	

TABLE 11

DIMENSION: DISCHARGE

ITEMS	PATIENT	RANKED PATIENT-THERAPIST AGREEMENT SCORES		RANK INTERVALS : .10
PO-CO	13	17	%	1.5
P1-C1	<u>14</u>	20		
P2-C2	<u>10</u>	29		3.5
P3-C3	11	29		
P3-C4	2	43		5.5
P4-C3	<u>7</u>	50		
P5-C5	4	57		7
	8	71		
	5	75		8.5
	1	86		
	6	86		12.5
	9	86		
	12	86		
	16	86		
	19	86		
	3	100		
	15	100		17.5
	17	100		
	18	100		

$$U = 3 \times 16 + \frac{16 \times 17}{2} - 179.5$$

= 4.5 Sign. at $p < .025$ one-tailed

TABLE 12

DIMENSION: OUTPATIENT TREATMENT

ITEMS	PATIENT	RANKED PATIENT-THERAPIST AGREEMENT SCORES			RANK INTERVALS = .05
P6-C6	13	36	%	1	1
P7-C7	8	41			2.5
P8-C8	<u>10</u>	42			
P10-C10 (1 and 2)	5	47			4
P10-C13 (1 and 2)	<u>7</u>	50			5
P13-C10 (1 and 2)	<u>14</u>	60			
P11-C11	11	61			7.5
P12-C12	12	61			
P14-C14	15	64			
P17-C17	17	72			10.5
P18-C18	18	72			
P19-C19 (1 and 2)	2	76			
P20-C20	9	77			
P21-C21	4	79			14
P22-C22	6	79			
P23-C23	19	79			
	1	80			17.5
	3	82			
	16	93			19

$$U = 3 \times 16 + \frac{16 \times 17}{2} - 175$$

$$= 9.$$

Sign. $.10 > p > .05$ one-tailed

TABLE 13

DIMENSION: MENTAL HYGIENE CLINIC CONTACT

ITEMS	PATIENT	RANKED PATIENT-THERAPIST AGREEMENT SCORES		RANK INTERVALS = .05
P26-C26	<u>14</u>	22	% 1	1
P27-C27	<u>10</u>	30	1	2
P28-C28	3	36		
P29-C29	4	36		4
P30-C30	11	36		
P31-C31	8	40		
P32-C32	<u>7</u>	44		7
P33-C33	12	44		
P36-C36	13	45	1	9
P37-C37	16	50		10.5
P38-C38	19	50		
P39-C39	1	56		12.5
P40-C40	2	58		
	9	60		
	5	64		15.5
	6	64		
	18	64		
	15	73		18.5
	17	73		

$$U = 3 \times 16 + \frac{16 \times 17}{2} - 180$$

= 4 sign. at $p < .025$ one-tailed

TABLE 14

DIMENSION: SIGNIFICANT OTHERS

ITEMS	PATIENT	RANKED PATIENT-THERAPIST AGREEMENT SCORES		RANK INTERVALS
P41-C41	<u>14</u>	33	%	
P42-C42 (1 and 2)	8	47		
P43-C43	6	50		
P44-C44	16	56		
P45-C45	4	57		
P46-C46	18	58	Nonsignificant by U test.	
P47-C47	15	60		
P48-C48	9	63		
P49-C49	1	67		
P50-C50	<u>7</u>	67		
P51-C51	3	71		
P52-C52	12	71		
P53-C55	11	75		
P54-C54	17	79		
P55-C53	13	80		
P56-C55				
P57-C57				

TABLE 15

DIMENSION: PRINCIPLES

ITEMS	PATIENT	RANKED PATIENT-THERAPIST AGREEMENT SCORES			RANK INTERVALS
P3-C3	<u>10</u>	22	%		1
P3-C4	5	28			2.5
P4-C3	11	29			
P8-C8	<u>14</u>	36			4.5
P10-C10 (1 and 2)	1	38			
<u>P10-C13</u> (1 and 2)	<u>7</u>	46			6.5
<u>P13-C10</u> (1 and 2)	12	47			
<u>P12-C12</u>	8	50			8.5
P26-C26	13	54			
P27-C27	4	57			10.5
<u>P43-C43</u>	15	57			
P44-C44	18	60			12.5
P45-C45	6	62			
P50-C50	2	67			
	16	67			15
	19	67			
	9	71			17.5
	17	73			
	3	81			19

Underlined items are
augmenting items.
Scores are for aug-
mented dimension

$$U = 3 \times 16 + \frac{16 \times 17}{2} - 178$$

$$= 6 \quad \text{Sign. at } p < .025 \text{ one-tailed}$$

TABLE 16

DIMENSION: CLINICIAN'S WISHES OF PATIENT

ITEMS	PATIENT	RANKED PATIENT-THERAPIST AGREEMENT SCORES	RANK INTERVALS
P13-C10 (1 and 2)	<u>10</u>	0 %	
P11-C11	5	50	
P18-C18	19	50	
P19-C19	8	57	
P38-C38	18	57	
P49-C49	<u>7</u>	60	
	9	60	
	4	67	
	11	71	
	12	71	Nonsignificant by U test.
	13	75	
	<u>14</u>	75	
	2	83	
	6	83	
	3	86	
	17	86	
	1	100	
	15	100	
	16	100	

TABLE 17

DIMENSION: PATIENT'S WISHES OF CLINICIAN

ITEMS	PATIENT	RANKED PATIENT THERAPIST AGREEMENT SCORES	RANK INTERVALS
-------	---------	--	-------------------

P10-C13	(1 and 2)		
---------	-----------	--	--

P32-C32			
---------	--	--	--

P53-C55			
---------	--	--	--

P56-C55			
---------	--	--	--

Because so few scores were obtainable
on this dimension, a U test was not performed.

TABLE 18

DIMENSION: CLINICIAN'S ACTS AND PLANS

ITEMS	PATIENT	RANKED PATIENT-THERAPIST AGREEMENT SCORES		RANK INTERVALS = .10
<u>P11-C11</u>	<u>10</u>	13	%	1
<u>P18-C18</u>	<u>14</u>	38		2
<u>P19-C19</u>	8	45		3
<u>P20-C20</u>	4	50		
P28-C28	<u>7</u>	50		5.5
P29-C29	13	55		
P30-C30	16	58		
P31-C31	3	60		
P33-C33	17	62		
<u>P38-C38</u>	2	67		10.5
<u>P49-C49</u>	5	67		
P51-C51	9	67		
P52-C52	18	67		
P55-C53	1	73		
	12	73		15
Underlined items are augmenting items.	6	75		
Scores are for augmented dimension.	(19	80)		
	11	82		17
	15	100		18

$$U = 3 \times 15 + \frac{15 \times 16}{2} - N_2$$

$$= 165 - 162.5$$

$$= 2.5 \quad \text{Sign. at } p < .01 \text{ one-tailed}$$

(Pt. 19 omitted due to few scores.)

TABLE 19

DIMENSION: PATIENT'S ACTS AND PLANS

ITEMS	PATIENT	RANKED PATIENT-THERAPIST AGREEMENT SCORES		RANK INTERVALS
P11-C11	<u>11</u>	20	%	
P20-C20	3	30		
P21-C21	15	33		
P22-C22	4	44		
P33-C33	<u>7</u>	57		
P36-C36	13	57		
P37-C37	8	60	Nonsignificant by U test.	
P46-C46	11	60		
P47-C47	2	71		
P48-C48	5	71		
	9	75		
	12	78		
	18	78		
	1	80		
	6	80		
	<u>10</u>	80		
	17	80		
	16	90		
	19	100		

TABLE 20

ALL ITEMS

PATIENT	RANKED PATIENT-THERAPIST AGREEMENT SCORES			RANK INTERVALS = .05
<u>11</u>	32	%		1
<u>10</u>	36			2
8	48			3
13	50			
<u>5</u>	53			5.5
<u>7</u>	53			
11	54			
4	58			
2	59			8.5
12	63			
6	64			10.5
16	68			
3	69			
15	69			13.5
18	69			
1	71			
9	71			16.5
19	76			
17	77			18.5

$$U = 3 \times 16 + \frac{16 \times 17}{2} - 181.5$$

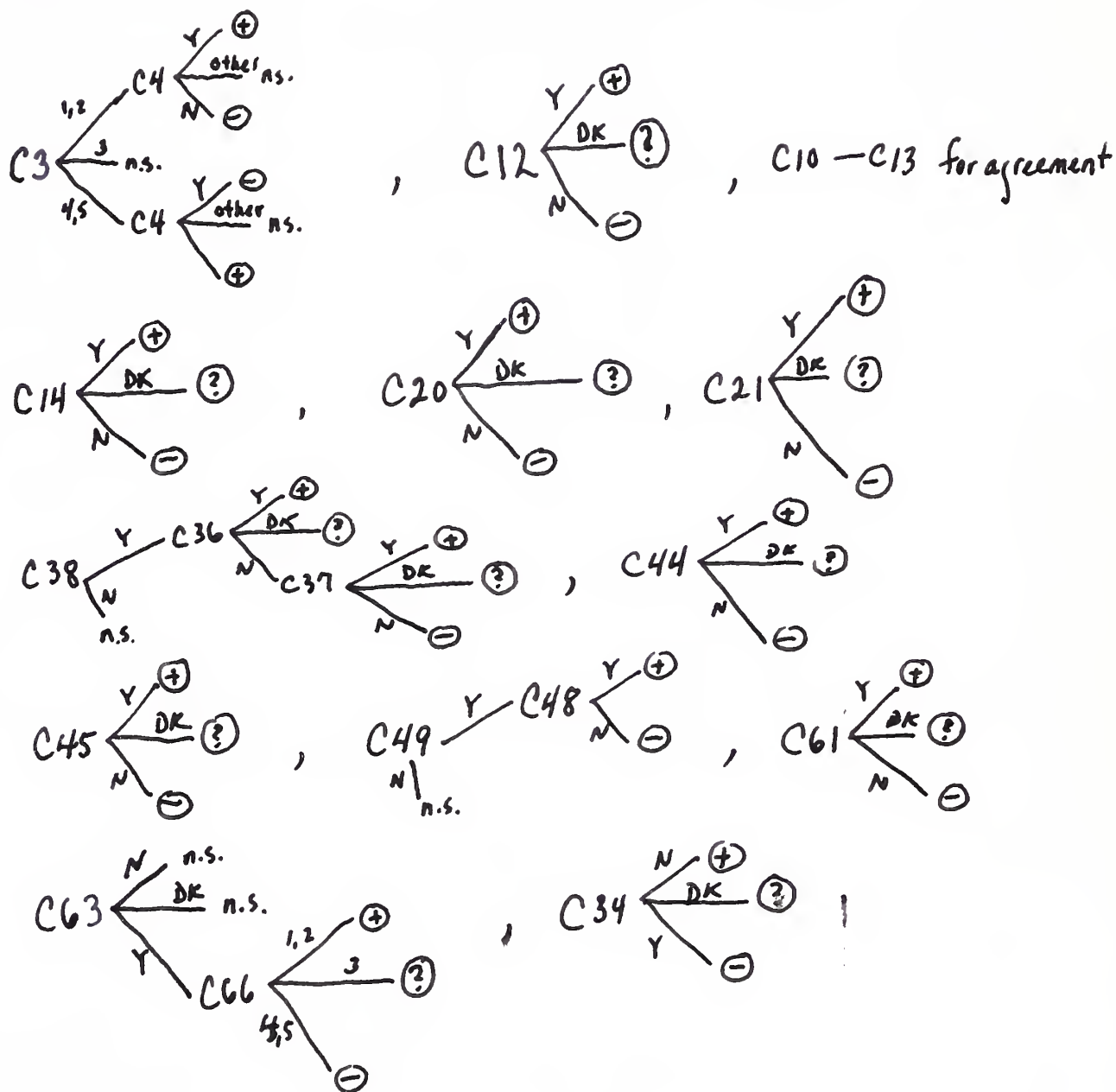
= 2.5 sign. at $p < .01$ one tailed.

TABLE 21

DIMENSION: THE GOOD PATIENT

Clinician question and responses: score \oplus (favorable), \ominus (unfavorable), or \odot don't know. ns = no score.

ITEMS:



To score, identify clinician's response to the left-hand question (for example, C3 meaning clinician question number 3) and follow the appropriate branch path either to a score (\oplus , \ominus , or \odot), to n.s., or to another question. Proceed similarly with each newly encountered question until item is scored or rejected without a score.

TABLE 22

DIMENSION: THE GOOD THERAPIST

Patient question and responses: scoring is the same as on The Good Patient.

ITEMS:

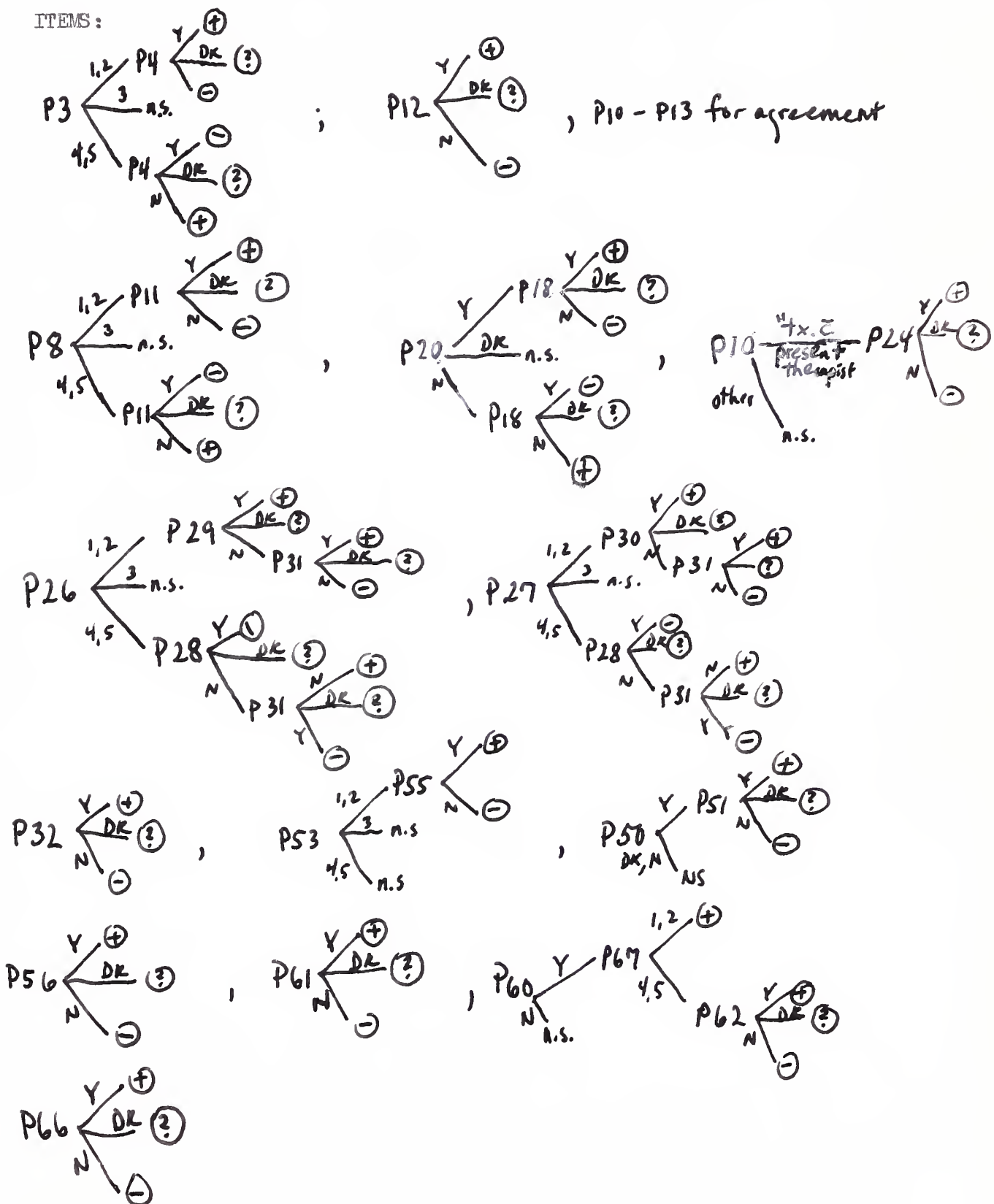


TABLE 23

DIMENSION: THE GOOD PATIENT

PATIENT	RANKED THERAPIST FAVORABLE RESPONSE		RANK INTERVALS
13	30	%	
15	30		2
1	33		
<u>10</u>	40		
<u>14</u>	45		5
3	45		
12	54		
18	54		7.5
<u>7</u>	60		
5	64		
11	64		10.5
2	69		
6	75		13
4	80		
17	80		
19	80		
8	83		16.5
9	86		
16	86		

$$U = 3 \times 16 + \frac{16 \times 17}{2} - N_2$$

$$= 184 - 169.5$$

$= 14.5$ nonsignificant

TABLE 24

DIMENSION: THE GOOD THERAPIST

PATIENT	RANKED PATIENT FAVORABLE RESPONSES	RANK INTERVALS
13	9 %	
<u>10</u>	25	
11	40	
5	50	
8	50	
6	60	
1	67	
<u>7</u>	67	
9	67	
12	67	
16	67	Nonsignificant U test.
4	71	
<u>14</u>	71	
17	80	
15	88	
18	88	
2	100	
3	100	

TABLE 25

AGREEMENT ITEMS RANKED BY OVERALL % AGREEMENT.

ITEM	% AGREEMENT	NUMBER OF RESPONSES	ITEM	% AGREEMENT	NUMBER OF RESPONSES
P52-C52	100	6	P10-C13 (2)	42.3	7
P42-C42 (1)	100	15	P33-C33	42.1	19
P47-C47	90.9	11	P10-C13 (1)	42.1	19
P18-C18	89.5	19	P49-C49	41.7	12
P 6-C 6	89.5	19	P12-C12	41.2	17
P 0-C 0	89.5	19	P 2-C 2	41.2	17
P41-C41	88.9	18	P19-C19 (2)	40	5
P43-C43	86.7	15	P39-C39	38.9	18
P14-C14	84.2	19	P53-C55	38.5	13
P11-C11	83.3	18	P58-C58	37.5	16
P 4-C 3	83.3	18	P37-C37	37.5	16
P38-C38	82.4	17	P13-C10 (2)	33.3	9
P20-C20	78.6	14	P48-C48	27.3	11
P21-C21	78.6	14	P45-C45	21.4	14
P 1-C 1	75	16	P10-C10 (2)	20	10
P17-C17	73.7	19	P31-C31	17.7	17
P19-C19 (1)	73.3	15	P56-C55	0	5
P46-C46	73.3	15	P32-C32	0	7
P36-C36	72.2	18			
P 5-C 5	72.2	18			
P55-C53	69.2	13			
P28-C28	68.4	19			
P22-C22	68.4	19			
P 8-C 8	66.7	18			
P50-C50	66.7	9			
P 3-C 4	64.7	17			
P13-C10 (1)	63.2	19			
P 7-C7	60	5			
P 3-C 3	58.8	17			
P29-C29	58.3	12			
P26-C26	57.9	19			
P10-C10 (1)	57.9	19			
P42-C42 (2)	53.8	13			
P51-C51	53.3	15			
P30-C30	50	12			
P44-C44	50	14			
P40-C40	50	4			
P27-C27	43.8	16			
P57-C57	42.9	14			

ITEM SUBORDINATION

Items	Subordinated to item
7	6
19-21	18
23	22
29-30	28
32	26,27,28 (pt. questionnaire)
34-35	33
40	39
42-57	41
47	46
52	51
54	53
56	53 (pt. questionnaire)

ANSWER CODES FOR OPEN QUESTIONS

QUESTION	CODE	CATEGORY
2.	0	1 day or less
	1	2-3 days
	2	4-7 days
	3	don't know
	4	8-14 days
	5	15-21 days
	6	22-28 days
	7	more than 28 days
7.	1	equal to or less than 6 months
	2	more than six months but less than or equal to 1 year
	3	don't know
	4	more than a year
9.	1	medication; "nerves"
	2	statement of complaint or of diagnosis(excluding "nerves" and alcoholism)
	3	don't know
	4	alcohol abuse
	5	statement of treatment goal
	7	statement of desired aspect of a therapy process.
10.	0	therapy with present ward therapist
	1	individual psychotherapy
	2	couples therapy
	3	don't know
	4	group therapy
	5	family therapy
	7	medication clinic or group
	8	talking therapy of unspecified kind
	9	patient doesn't know; patient doesn't want any (used only for clinician response)
13.	SAME AS 10	
19.	0	a tricyclic
	1	lithium carbonate
	2	oral phenothiazine
	3	don't know
	4	Prolixin I.M.
	5	Haldol

QUESTION	CODE	CATEGORY
23.	0	"hometown," without further specification
	1	another mental health clinic
	2	a private psychiatrist
	3	don't know
	4	private M.D. for somatic complaints
35.	0	patient wants present therapist, contrary to plan
	1	patient wants individual, clinician recommends group
	3	don't know
40.	1	someone among the patient's present ward staff
	2	someone from the MHC not among present ward staff contacts of patient
	3	don't know
	4	person at patient's home.
42.	0	wife
	1	mother
	2	father
	3	don't know
	4	parents
	5	girlfriend, lover
	7	patient's child or children
	8	friends
	9	sibling or other relative not already categorized
47.	SAME AS 42.	
52.	SAME AS 42	
54.	SAME AS 42	

INFORMATION ABOUT: Referral of Psychiatric Inpatients to the Outpatient Clinic
at the West Haven Veterans Administration Hospital

You are invited to participate in a study which examines how patients discharged from the inpatient wards of the psychiatric service of this hospital are referred to the outpatient clinic for continuing treatment. We know that some patients keep their appointments for outpatient treatment and others do not. This study will investigate some of the reasons for this difference, and may help to improve the way referrals are made.

The procedure to be used, if you decide to participate, will be for you to meet with the study investigator for about fifteen minutes. He will ask you some questions about whom you met and spoke with concerning your referral to the outpatient clinic, and whether you were satisfied with the way your referral was handled. Your answers will be kept confidential. Also if you participate, similar questions about your referral will be asked of your inpatient therapist, and of clinicians from the outpatient clinic. The principal investigator will have access to your hospital chart in order to obtain certain medical data including your attendance at outpatient therapy after your discharge. All of this information will also be kept confidential.

A possible inconvenience to you of taking part in this study is the need for you to speak to the study investigator, preferably before you are discharged from your inpatient ward. Your answers to questions during this interview will not affect your referral or your future treatment in any way.

A possible benefit to you of taking part in this study is that speaking with the study investigator may make your referral to the outpatient clinic clearer to you.

If you choose not to participate in this study, your referral and your future treatment will not be affected.

If you have any questions at any time concerning this procedure, we will be most happy to answer them at any time. You are free to decline entrance into or to withdraw your participation in this study at any time. Such refusal or withdrawal will not affect your care and treatment in any way.

I agree to participate in this study.

Date

Subject

Witness's Name and Address

Signature of Witness

Investigator

TABLE 26

SCREENING QUESTIONS: CLINICIAN SCORES

PATIENT	C8	C14	C17	C22	SUM
1	1	1	1	-1	2
2	1	1	1	1	4
3	1	1	1	0	3
4	1	1	1	1	4
5	1	1	0	1	3
6	1	1	1	1	4
<u>7</u>	0	1	1	1	3
8	1	1	1	1	4
9	1	1	1	1	4
<u>10</u>	1	1	1	1	4
11	1	1	1	1	4
12	1	1	1	1	4
13	1	0	1	0	2
<u>14</u>	1	0	0	0	1
15	1	0	1	1	3
16	1	1	1	1	4
17	1	1	1	1	4
18	1	1	1	1	4
19	1	1	1	1	4

Calculation: the poor-outcome triplet have scores of 4,3,1. The total number of triplets possible is $19!/16!3! = 969$. The triplet scores listed below are as unfavorable or more unfavorable than the poor-outcome triplet scores: each triplet is listed with the number of separate ways of making it up from the sample above.

(1,2,2)-1; (1,2,3)-8; (1,2,4)-24; (1,3,3)-6; (1,3,4)-48
 (2,2,3)-4; (2,2,4)-12; (2,3,3)-12. Total ways 115.

Chance of picking a triplet at least as unfavorable by this definition as the poor-outcome triplet is $115/969 = .12$

TABLE 27

SCREENING QUESTIONS: PATIENT SCORES

PATIENT	P8	P14	P17	P22	SUM
1	1	1	1	-1	2
2	1	1	1	1	4
3	1	1	1	1	4
4	1	1	1	1	4
5	0	1	1	-1	1
6	1	1	1	1	4
<u>7</u>	1	1	-1	1	2
8	1	1	-1	-1	0
9	1	1	0	1	3
<u>10</u>	0	1	1	1	3
11	-1	1	1	1	2
12	0	1	1	1	3
13	-1	1	1	1	2
<u>14</u>	1	1	1	1	4
15	1	1	1	1	4
16	1	1	1	1	4
17	-	1	1	0	2
18	1	1	1	1	4
19	1	1	1	1	4

Calculation: the principle is the same as on previous Table except a glance shows this case to be far less favorable for finding that a low group score (as low as that of the poor outcome group) is a rare event.

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